Westland Family Foot & Ankle Specialists

33777 N Scottsdale Rd STE 101
Scottsdale, AZ 85266
TEL: 480-361-2500
FAX: 602-513-7309
www.westlandffas.com

Authorization to Disclose Health Information

Patient Information:

First Name: _____ **Last Name:** _____

Address: _____ **Date Of Birth:** ____/____/____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** _____

Release Information To:

Name/ Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Fax Number:** _____

Email: _____

Purpose of Request: ☐ **Personal** ☐ **Treatment** ☐ **Legal** ☐ **Insurance** ☐ **Disability**
☐ **Transfer Care/ Reason:** _____ ☐ **Other**

Personal Requests: There will be a $15 flat fee and an additional $0.25 fee per page for all requests on paper.

Authorization to Release Protected Information:

-This authorization will expire 90 days from the date signed. I understand that I may revoke this authorization at any time by notifying the facility where my medical records are kept, in writing.
-I understand that my treatment or continued treatment by Westland Family Foot & Ankle Specialists is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
-I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, HIV. If may also include information about alcohol or drug use.
-I understand that once information has been disclosed, Westland Family Foot & Ankle Specialists can no longer protect it from further disclosure.

Patient's Signature: _____ **Date:** _____

Parent/ Legal Guardian Signature: _____ **Date:** _____

Relationship: _____

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Office Visit Notes
☐ Hospital Progress Notes
☐ Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports
☐ Other _____

Notes:

_____