ORLANDO FOOT & ANKLE CLINIC
Personalized foot pain solutions for active adults

P.O. Box 140233
Orlando, FL 32814-0233
Ph: 407-423-1234 Fax: 407-517-1040

CONSENT FOR RELEASE OF CONFIDENTIAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone Number: _____ SSN: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the use or disclosure of the above named patient's health information.

RELEASE FROM:

Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____

RELEASE TO:

Name: _____
Address: _____
City: _____
Phone: _____
Fax: _____
Email: _____

Information to be disclosed:

☐ Office Notes ☐ Operative Reports ☐ Lab Results ☐ Diagnostic Reports ☐ X-Ray Films

☐ All ☐ Other _____

Specified Dates of Service: _____

Release records for the purpose of:

☐ Changing Physicians ☐ Personal File ☐ Specialist ☐ Insurance ☐ Legal ☐ Other

This request is authorized to include any Federal and/or State protected information under Florida Statutes 394.459(9) Psychiatric Information, 397.053/396.112 Drug and/or Alcohol Abuse Information, 381.609 HIV and AIDS related conditions and/or 397.501(3) records of a minor client.

I understand that this authorization will expire 90 days from the date of signature or when acted upon, whichever event occurs first. I hereby release to the forwarding addressee, its employees and appointed representative from any and all liability that may arise from the release of information as I have directed.

This authorization for the release of the above indicated documents may be revoked at any time upon notification of the patient or representative as signed above. Revocation has no effect on prior action taken under direction of the signed/dated consent for release.

Signature (Patient/Legal Guardian) _____ **Date** _____

****CHARGES: $10 FEE FOR RECORDS BEING RELEASED TO PATIENT DIRECTLY****