Montgomery Foot Care Specialists
"Exceeding your Expectations"
www.montgomeryfootcare.com

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# Authorization to Use or Disclose Health Information

Patient Name: _____ DOB:_____ ID#:_____

I authorize the use or disclosure of the above-named individual's health information as described below.

1. Montgomery Foot Care is authorized to make the disclosure.
2. The type of information to be used or disclosed is as follows:(check one)
   - ☐ entire medical record
   - ☐ lab results (please describe the dates or types of lab tests you would like disclosed):
     _____
   - ☐ x-ray and imaging reports (please describe the dates of x-rays you would like disclosed): _____
   - ☐ other (please describe): _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. The information identified above may be used or disclosed to the following individuals or organizations(s):
   **Montgomery Foot Care Specialists**
   **1831 Halcyon Blvd.**
   **Montgomery, AL 26117**
   **Email to:joni@montgomeryfootcare.com**
   **Fax: 334-396-3660 Attn: Joni**
5. The information for which I'm authorizing disclosure will be used for the following purpose:
   ☐ my personal records ☐ sharing with other health care provides ☐ other: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Montgomery Foot Care. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides may insure with the right to contest a claim under my policy.
7. This authorization will expire 1 year from the signed date. (12 months or 365 days)
   If I fail to specify an expiration date, this authorization will expire in six months from signature date.
8. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the `information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ Date: _____
Patient Signature

If signed by a legal guardian
Name: _____ Relationship: _____

_____
Signature