

Advanced Ankle & Foot Centers

Release of Medical Records / Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your rights to patient confidentiality. If you have any concerns please feel free to discuss them with our office manager.

Medical Records Information Release

I understand that by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the Social Security Administration and the Health Care Financing Administration, or it's intermediaries, or carriers and information needed for this or any related claim.

_____ Initials

Medical Record Release to/from Hospitals /Physicians

I authorize the release of my medical information to/from other physicians as needed to provide my care. I further authorize release to/from hospitals and /or healthcare facilities as pertaining to my care. I understand that my records may be faxed to/from hospitals and/ or physicians and that all-reasonable efforts will be made to maintain confidentiality. _____ Initials

Medical Records Release to Family

I authorize Advanced Ankle & Foot Centers to release information pertaining to my illness and or treatment to: _____. I authorize Advanced Ankle & Foot Centers to leave medical information on my answering machine. I also authorize information to be given to my spouse.

_____ Initials

Patient Rights to Confidentiality

I understand that Advanced Ankle & Foot Centers' office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Georgia law, I have the right to my medical records. I further understand that I may request that my records be released to a physician and or medical facility; however this request must be made in writing. I understand that by law this office may only release medical records that were generated by Advanced Ankle & Foot Centers. We cannot release medical records from any other physician, hospital, or facility. I agree to accept responsibility for a copying fee as provided by Georgia statutes. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to this practice or to the Secretary of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

_____ Initials

Print Name

Signature

Date