



ORLANDO
FOOT & ANKLE
CLINIC

Personalized foot pain solutions for active adults

P.O. Box 140233 • Orlando, Florida 32814-0233
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CONSENT FOR RELEASE OF CONFIDENTIAL RECORDS

Patient Name:	Phone Number:
DOB:	
SSN:	
Purpose / Need For Information: <input type="checkbox"/> Application for Insurance <input type="checkbox"/> Changing Physicians <input type="checkbox"/> Regarding Insurance Claim <input type="checkbox"/> Specialist	Special Instructions:

SPECIFIC DOCUMENTATION REQUIRED:

- Documents in our possession from other sources Medical Records in our possession from other sources _____
 Laboratory Reports Our Medical History/Physical Exam _____

Information Requested From:	Forward Documentation To:

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to me during the period:

FROM _____ TO _____

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 below 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.

Signature of _____ Date: _____

Empowered Representative: _____ Date: _____
(Parent/Guardian if applicable)

Relationship to _____ Date: _____

Witness: _____ Date: _____

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.