

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth / /  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_

### I AUTHORIZE DALLAS PODIATRY WORKS TO RELEASE TO:

Name: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORDS:

Please check the appropriate box(es):

- |  |   |
|--|---|
| <input type="checkbox"/> Entire Medical Record, excluding X-rays                 | <input type="checkbox"/> Operative Reports  |
| <input type="checkbox"/> Entire Medical Record, including X-rays*                | <input type="checkbox"/> MRI Films & Report |
| <input type="checkbox"/> X-rays only (*Our office uses filmless digital imaging) | <input type="checkbox"/> Doctor's Notes     |
| <input type="checkbox"/> Laboratory Reports                                      |   |
| <input type="checkbox"/> Other: _____  |   |

Approximate \_\_\_\_\_ date(s) \_\_\_\_\_ of \_\_\_\_\_ treatment:  
 Purpose/Need: \_\_\_\_\_

I would like to arrange for the transfer of records to made by:

- Pick up records from Dallas Podiatry Works Medical City Dallas office  
 Pick up records from Dallas Podiatry Works Baylor Plano office  
 Secure Fax # \_\_\_\_\_  
 Email to the following address: \_\_\_\_\_  
 USPS / FedEx to the delivery address below (shipping & handling fee will apply for FedEx—upon request, the charge can be directed to your FedEx account):

Recipient's phone number: ( ) - \_\_\_\_\_

Delivery Address:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Signature (Patient or Legal Guardian):** \_\_\_\_\_

**Date:** / /

### NOTICE TO PATIENT

*I understand that this consent is valid for 90 days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to any Dallas Podiatry Works physician of my choice except to the extent that Dallas Podiatry Works has already acted in reliance on this contract. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. This authorization will automatically expire when the information requested has been released if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed.*

**CHARGES:** The following charges apply to records copied for personal use, insurance and attorneys.

Pages 1—25: \$1.00 per page

Pages 26—50: \$0.67 per page

Pages 51 and up: \$0.33 per page

X-rays: \$8 per X-ray

MRIs: \$10 per copy

**We require a minimum of five business days after receipt of signed release to process request.**