

**AFFILIATES IN FOOT CARE  
100 Unicorn Park Dr., Suite 3  
Woburn, MA 01810**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Affiliates in Foot Care, PC and its staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Person/Organizations receiving the information:

\_\_\_\_\_

Specific Information Requested (including dates):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that this authorization will expire on \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy) Initials: \_\_\_\_\_

I understand that I may revoke this authorization for the requested use or disclosure at any time by notifying Affiliates in Foot Care, PC in writing. It will not have any affect on any actions taken before receipt of my revocation. Initials: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
Signature of patient or patient's representation Date  
(Form MUST be completed before signing.)

\_\_\_\_\_  
Printed name of patient's representative (if applicable)

\_\_\_\_\_  
Relationship to the patient (if applicable)

**YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**