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)
Intials: _____

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