

AUTHORIZATION TO USE OR DISCLOSE PORTECTED HEALTH INFORMATION

I hereby authorize Foot & Ankle Specialists, P.C. to discuss and/or disclose my Persona Health Information (PHI) to the following individual's as described below:

____ Spouse _____
____ Adult Child(ren) _____
____ Parents _____
____ Other _____

Expiration: This authorization will stay in effect unless I set an expiration date, or it is otherwise revoked. _____

Patient Name (Please Print)

Date of Birth

Patient Signature

Date

Witness