SHOAL CREEK
FOOT & ANKLE CENTER

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Request for Medical Records

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Address, City, State, ZIP:_____

I authorize Shoal Creek Foot & Ankle Center to take the following action:

☐ Obtain my protected health information from: ☐ Release my protected health information to:

Provider/Facility:_____

Address, City, State, ZIP:_____

Phone:_____ Fax:_____

For this authorization, "my protected health information" means:

☐ All records	☐ History and physical	☐ Hospital reports
☐ Lab/pathology reports	☐ Medications	☐ Operative reports
☐ Progress notes	☐ Radiology reports/images	☐ Other:_____

Date(s) of service requested:_____

☐ For my healthcare treatment ☐ At my request ☐ Other:_____

I understand that:

(1) This authorization is voluntary. My treatment will not be impacted, no matter if I sign this authorization or not. (2) This authorization is valid for one year from the date signed unless an earlier date is specified here:_____. (3) I may revoke/withdraw this authorization at any time by providing written notice; however, revocation/withdrawal will not apply to any previous release information. (4) Once my protected health information is disclosed as requested, it may no longer be protected by federal and state privacy laws. (5) The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug, and alcohol abuse, etc. (6) There may be a fee for a copy of my protected health information. I agree to pay this fee.

Patient/Patient Representative Signature:_____ **Date:**_____

Relationship to Patient:_____