JENSON FOOT AND ANKLE SPECIALIST

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____
Date of Birth: _____ Social Security Number: _____

NOTE: Release of Records – For records requested from a patient's previous physician, the patient must provide a complete physician name and physician office phone and fax number or address to ensure the request can be complete.

Authorizes: Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____ Office Fax: _____
To Release information To ☐, or get information From ☐

Dr David Jenson, Profoot Center
111 Vision Park Blvd, Suite 240
The Woodlands, TX 77384
Phone (936) 273-6000 Fax (936)273-6022

_____ Laboratory / Pathology Reports _____ Imaging Reports / X-Rays _____EKG Reports
_____ Progress / Office Visit Notes _____ Complete Medical History _____ Billing Records
_____ Other Specify _____

This authorization covers patient care given from _____ (date) to _____ (date)

_____ (initials)☐I DO (or)☐DO NOT consent to the release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results of such disclosure shall be limited to the following specific types of information: _____

Purpose of Disclosure: ☐Medical ☐Care ☐ Attorney ☐ Insurance ☐Other _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke the authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid. ☐Yes ☐No

I understand that when this is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my Protected Health Information.

Patient Signature _____ Date _____
Legal Representative Signature _____Relationship to Patient _____
Witness Signature _____ Date _____

PROHIBITION ON REDISCLOSURE This information has been disclosed to you from our records whose confidentiality may protected by Federal Law. Federal regulations may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information may not be sufficient for this purpose. Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient (42 CFR Part 2 applies only to substance abuse records.)