Temple University School of Podiatric Medicine

AUTHORIZATION TO RELEASE SPECIAL INFORMATION

	Patient Identification Data	
Full Name	Date of Birth	MR#
Address	City/State/Zip	Phone Number

I hereby authorize TEMPLE UNIVERSITY SCHOOL OF PODIATRIC MEDICINE to furnish from my medical records to: _____

(Name of person or Organization)

Address	City	State/Zip

Type of Access
This information I am authorizing to be disclosed will be used for the following purpose: ☐ Sharing with other health care providers as needed for treatment purposes ☐ My personal record ☐ Review of record in department ☐ Copies of my record I understand if needed for my personal use there will be a fee that must be paid prior to my receiving the photocopied records. ☐ Other (please describe):

Scope
Specify nature and extent of information to be disclosed (check ✓ appropriate boxes):
Entire Medical Record
Portion of medical record. Indicate specific portion/dates:
Imaging studies. Indicate specific study & dates:
Other:
Disclosure may include information relating to psychiatric, drug/alcohol and/or HIV or AIDS related information. This authorization is effective for the period from _____ to _____. If no expiration date is specified, it will expire 6 months from the date it was signed.
As required by the Health Information Portability and Accountability Act (HIPAA), you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request cannot be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than the health care provider.
The authorization is subject to my revocation at any time by writing to the Custodian of Records, Foot and Ankle Institute, 8th at Race Street, Philadelphia, PA 19107, 215-777-5808 phone, 215-777-5825 fax. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when they law provides my insurer with the right to contest a claim under my policy. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information. I understand authorizing the use or disclosure of the information identified above is voluntary and that I do not need to sign this form to ensure healthcare treatment. This authorization form has been fully explained to me and I certify that I understand its contents. _____ _____ Patient Signature Date _____ _____ Witness Name Witness Signature
NOTE: Authorization must be signed by the patient or the next of kin in case of a minor, or by legal guardian when the patient is physically or mentally incompetent. If signed by other than patient, please state reason.