AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION
from ADVANCED ANKLE and FOOT SURGEONS, LLC.

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number _____

I Authorize and Request: _____

(Provider's Name)
Advanced Ankle and Foot Surgeons, LLC
4600 Memorial Drive, Suite 80
Belleville, Illinois 62226

To Release to: _____

_____

_____

_____ _____
Office Phone Office Fax

Medical Records covering the periods of health care from _____ to _____
Date Date

Information to release: **(NOTE– The patient must check and initial to allow release of the following information.)**

☐ OB/GYN Records ☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History
☐ Psychiatric Evaluation ☐ Other (please specify) _____

The Medical Information is needed for: _____.

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will **expire ninety (90)** days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____ _____
Signature of Patient (if the patient is incompetent, of his guardian or other) ***Relationship*** ***Date***

_____

Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent or sibling.