10601 Pecan Park Blvd. Suite 301B
Austin, TX 78750-1448
Phone: (512) 719-4545
Fax: (888) 896-7756
frontdesk@austinfootsurgery.com

Brent S. Wood, DPM
Foot and Ankle Specialist

Authorization for Release of Medical Records

Attention: Medical Records

Patient Name: _____ Date of Birth: ____/____/____

Release records to:

Name: _____

Fax: _____

Release records from:

Name: _____

Fax: _____

Please send a copy or summary of the following medical records:

___ Complete Medical Records
___ Lab Result(s)
___ Surgical Procedure(s)
___ Other: _____
___ Consultation Report(s)
___ Pathology Report(s)
___ X-Ray(s)

___ For Dates of Service from ___/___/___ to ___/___/___ ___ For all Dates of Service

Purpose:

___ Continued Care ___ Insurance ___ Personal

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___ Yes, I consent to the release of this information ___ No, I do not consent to the release of this information

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand 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 the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires within one year of completion of this request.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office of Dr. Brent S. Wood, D.P.M. PLLC.

I understand that there may be a reasonable medical records copying fee as permissible by state law.

Patient/Guardian Print Name: _____ Date ____/____/____

Patient/Guardian Signature: _____ Relationship: _____