NYOTA
MEDICAL FOOTCARE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH:_____
PATIENT MEDICAL RECORD #_____
PATIENT ADDRESS: _____ APT. #:_____
CITY: _____ STATE: _____ ZIP CODE:_____
TELEPHONE CONTACT #: DAY: (___) _____EVENING: (__) _____

I, (Patient Name/Legal Representative) _____ do hereby authorize

(**Provider/Facility**)_____, **Phone**:_____

Fax:_____ to release my protected health information including copies of my medical record of care to the following person at the location listed below, for the purposes described:

Nadege Momplaisir, MSN, CFCS, ANP-C| Nyota Medical Footcare, PLLC| Fax: 980-500-2086

INFORMATION TO BE RELEASED (Specify dates)	PURPOSE
○ **Clinic Visit Notes_____** ○ **Discharge Summary_____** ○ **Lab Reports_____** ○ **Operative Note_____** ○ **Pathology Reports_____** ○ **Xray/Scan Reports**	○ Medical care ○ Insurance* ○ Legal matter* ○ Myself* ○ Other (please specify below)

This Authorization Expires in, check appropriate box: ☐ 3months ☐ 6months ☐Other: Indefinitely while receiving care at Nyota Medical Footcare clinic. *If not specified, all authorizations will expire 12 months, from the date this form was signed.*

*Additional charges may be associated with this request.

I understand that:
I May withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
- to the extent that action has been taken in reliance on this authorization.
- if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
Information released on this authorization, if redisclosed by the recipient, is no longer protected by Nyota Medical Footcare

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.
Patient's Signature: _____ Date: _____

Print Name: _____
When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.
Signature of Legal Representative:_____ Date: _____

Print Name:_____ Relationship of representative to patient: _____