Eugene Foot and Ankle Health Center

Release of Information and HIPAA Privacy Policy

Release of information: I authorize the following persons or entities to communicate with Eugene Foot and Ankle Health Center regarding my medical records (Lab results, imaging results, care, billing information, etc). If only authorizing particular categories of medical information to be released, please specify below.

Patient Name:_____ DOB:_____

Name (person to release info to)	Type of information to be released
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient/Guardian Signature Date

If fifteen or older, patient must authorize access to the above mentioned information.

HIPAA Privacy Policy:

I acknowledge that I was notified of the Notice of Privacy Practices and that I have had the opportunity to read it, if I choose, or be provided a copy of it.

Pt/Responsibly Party _____Date:_____