

Authorization for Use, Access and Disclosure of Protected Health Information (PHI)

Patient Name _____ DOB _____

Address _____

Phone _____ Last 4 digits soc sec _____

Signature _____ Date _____

I hereby authorize Dr. David E. Condon to release medical records and/or health information regarding my history, condition and treatment to:

(Name and phone number of individual/s to receive information)

or:

Physician's Name (that you wish Dr. Condon to send Medical records **to/or receive records from**< circle which >)

Physician's Address _____

Physician's Phone / Fax _____ / _____

I hereby authorize and request the release of my medical records **to/from**< circle which >:

David E. Condon, DPM

PO Box 10069 Truckee, Ca 96162

(530)587-7790, Fax (530) 587-4293

Purpose for the Authorization: _____

Expiration: This authorization shall expire: _____ **or** _____indefinite.

I understand that this authorization may be revoked by me in writing at any time, except to the extent that action has been taken in reliance upon it. The Revoke Authorization Form must be used and is available upon request. I also understand that though federal law does not protect health information which is disclosed to someone other than another health care provider, plan or clearing house, under California law all recipients of PHI are prohibited from re-disclosing it except as specifically required or permitted by law. I understand that refusal to sign this authorization will not affect my health care, except as pertains to the release of the information requested.