InStride Central Carolina Foot & Ankle Associates

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Authorization to release Protected Health Information (PHI) to / from Central Carolina Foot & Ankle Associates
(circle one)

Patient Name: _____ Date of Birth: _____

Patient Address: _____Phone: _____

Request Date: _____ Chart: _____

I hereby request and consent to the release and disclosure of my personal health information from / to (circle one):

Facility/Doctor/Person: _____

Address: _____Phone: _____

Please include (Check all that apply):
- ☐ Entire medical record (additional fee applies based on size of record)**
- ☐ Partial records, from _____to_____
- ☐ Financial records
- ☐ Xray Reports
- ☐ CD with Digital X-rays ($5 fee, must be picked up from office)
- ☐ Other: _____

Please send this PHI (check one):
- ☐ Via secure fax to CCFA at: 919-477-9389
- ☐ Via mail to CCFA: InStride Central Carolina Foot & Ankle Associates, 2609 N. Duke St, Suite 301, Durham, NC 27704

- ☐ Via fax to other facility/doctor: _____
- ☐ Via mail to address indicated above ($5 fee applies)**
- ☐ I will pick up my records

**when additional fees are assigned they must be paid prior to release of information

I certify that I am aware that:
- I have the right to revoke this authorization at any time. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- I may inspect of copy the protected health information to be disclosed as described in this document.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.
- I may incur fees for requesting my health record to be released.

_____ _____
Signature of Patient or Personal Representative (attach necessary documentation) Date

Patient's initials/date upon receipt of requested health information: _____ Date _____