Gateley Podiatry, P.A.

Authorization to Disclose/Obtain Health Information

This authorization permits Gateley Podiatry to disclose/obtain your health information, including information about medical treatment, mental health treatment and HIV/AIDS status. Please review carefully.

PATIENT NAME _____ DOB: _____

ADDRESS _____CITY, STATE & ZIP_____

PHONE _____ ACCT NUMBER _____

I authorize the below: to disclose my health information to:

Gateley Podiatry	_____
(Name)	(Name)
6730 SW Mission View Drive	_____
(Address)	(Address)
Topeka, Kansas 66614	_____
(City, State, Zip)	(City, State, Zip)
(785) 783-8983	_____
(Fax Number)	(Fax Number)

For the following designate purpose: ____ Personal ____ Further Medical Care ____ Worker's Comp____ Insurance ____ Legal

Records to be disclosed: ____ All Records ____ Progress Notes ____ Operative Reports____ Lab ____PT ____Billing ____X-rays
____ Other- specify _____

The approximate dates of service to be obtained are from _____ to _____

I understand that this authorization will expire one year from the date of my signature or upon the following event:
_____

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.
I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that a fee may be charged for copies of my medical record. If I have questions about disclosure of my health information, I can contact the designated Privacy Officer.
Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

I authorize Gateley Podiatry to obtain/disclose the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit Gateley Podiatry to obtain/disclose the records/information upon presentation of a photocopy of this authorization.

Patient/Personal Representative Signature _____

Relationship of Personal Representative to Patient _____ Date _____