WESTWOOD FOOT CLINIC

669 Winnetka Ave. N. Suite 201
Golden Valley, MN 55427
(763) 231-2341 Fax: (763) 231-2343

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

Patient Information:

Name: _____ Previous Name(s):_____

Address: _____ City: _____ State:_____ Zip: _____

Date of Birth: _____ SS# (optional):_____

Home Phone: _____ Other Phone: _____

Who do you want to receive this medical information?

I hereby authorize, and request that the Westwood Foot Clinic/Thomas E. Silver, D.P.M., P.A. release copies of my medical information that are created and maintained by their facility to:

(Provider or clinic to send information to):_____

Address:_____ City: _____ State:_____ Zip: _____

Phone:_____ Fax:_____ Additional Info: _____

Which information would you like disclosed?

□ Medical Records □ Lab reports □ Itemized Billing □ X-rays (CD) □ Surgical Records
□ Radiology reports □ Other: _____
□ Verbal disclosure of medical information-Please check here if you are completing this form for verbal communication consent only to another provider or facility.

The reason for disclosure of this information is for the following:

□ Patient's Personal Use □ Insurance □ Worker's Compensation
□ Disability □ Legal □ Continuing Care □ Second Opinion

When does this information need to be received by?

Date: _____(please allow 2 weeks for transfer)

How would you like the information to be sent?

□ Mail □ Pick up at Westwood Foot Clinic (date/approx. time):_____
□ Fax:_____ (Records can only be faxed to clinics/providers)

I hereby authorize, and request that the Westwood Foot Clinic release my health information that is created and maintained by their facility. I understand that I may revoke this consent at any time in writing. Revocation becomes effective once written request is received by the Westwood Foot Clinic. This authorization will automatically expire in one year from the date of signing. I understand that I will not be refused treatment if I choose not to sign this authorization. I realize that the above stated medical facility cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to the privacy rule protections.

Signature of: Patient_____ Date:_____

Guardian *: _____ Date:_____
Relationship to patient: _____
*If signed by legal guardian, please send copies of legal documentation for representation and relationship to this patient.