CNY Foot Surgery
& Podiatry Care P.C.

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: ___ / ___ / ___

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be release to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____

[ ] Information is not to be released to anyone.

The ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date of Signature : ___ / ___ / ___

Witness: _____ Date of Signature : ___ / ___ / ___