

**AFFILIATES IN FOOT CARE
100 Unicorn Park Drive, Suite 3
Woburn, MA 01801**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Affiliates in Foot Care, PC and it's staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____ DOB: _____

Person/Organizations receiving the information:

Specific Information Requested (including dates):

I understand that this authorization will expire on ___/___/___ (mm/dd/yyyy)

Initials: _____

I understand that I may revoke this authorization for the requested use or disclosure at any time by notifying Affiliates in Foot Care, PC in writing. It will not have any affect on any actions taken before receipt of my revocation.

Initials: _____

_____/_____
Signature of patient or patient's representation
(Form MUST be completed before signing.)

Date

Printed name of patient's representative (if applicable)

Relationship to the patient (if applicable)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION