HIPAA Privacy Authorization Form

1. I, _____ authorize Bedford Podiatry & Foot Surgery, PC to use and disclose the protected health information described below to _____ _____(individual seeking the information), spouse, child(ren), parent, other.

2. This authorization for release of information covers the period of health care from:
   a. _____ to _____.
   OR
   b. all past, present, and future periods.

3. a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
   OR
3. b. I authorize the release of my complete health record with the exception of the following information:
   ◯ Mental health records
   ◯ Communicable diseases (including HIV and AIDS)
   ◯ Alcohol/drug abuse treatment
   ◯ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient / personal representative _____

Printed name of patient / personal representative and his/her relationship to patient

_____ Date _____