Print Patient Name______________________________________ **Date of Birth**___________________

Ability Foot & Ankle PLLC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Ability Foot & Ankle PLLC, and any associated physician to release information concerning the medical history and treatment for purposes of insurance claim processing. I have read, understood, and accurately answered all questions above and assume responsibility for payment of account (including those fees which are not paid through medical insurance).

SIGNATURE____ **DATE**______________________

I request that payment of authorized medical insurance benefits be made on my behalf to Ability Foot & Ankle PLLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the health care financing administration or the involved health insurance company and its agents any information needed to determine these benefits or the benefits payable to related services.

SIGNAUTRE____ **DATE**______________________

AUTORIZATION TO RELEASE PRIVATE/MEDICAL INFORMATION

I authorize Ability Foot & Ankle PLLC to release private/medical information to the following:

____ __________________________

(Name of person authorized to receive information) (Relationship to patient)

____ __________________________

(Name of person authorized to receive information) (Relationship to patient)

HIPAA PRIVACY NOTIFATION

Ability Foot & Ankle PLLC has provided me with their HIPAA compliant notice of privacy policy.

SIGNATURE____ **DATE**_________________