MORE THAN JUST PODIATRY

Office of Dr. James Sills-Powell

1776 Crosswinds Drive
Wentzville, MO 63367

3701 N. St. Peters Pkwy Ste C
St. Peters, MO 63376

Phone: (314) 735-5197 | Fax: (314) 338-3495
www.mttinc.biz |info@mttinc.biz

Authorization for Use or Disclosure of Protected Health Information

Name of Patient: ________________________ Date of Birth: ____________

Social Security #: ________________________ Contact: ____________

Address: ____
Street **City/State** **Zip Code**

I authorize ____
Street **City/State** **Zip Code**

to disclose my medical records as indicated below to:

More Than Just Podiatry office of James Sills-Powell, DPM
Name of Company/Provider/Individual

1776 Crosswinds Drive **Wentzville MO** **63385**
Address **City, State** **Zip Code**

Specific information to be released:	**My purpose/use of the information:**	
____ Office Visits	___ Changing physicians	____ 2nd Opinion
____ Lab Reports	___ Continuing care	____ Legal
____ X-Ray Reports	___ At my ( ) request	____ Insurance
____ Consult Reports	___ Workers' Compensation	____ School
____ Operative Reports	___ Other ____________________	
____ Other ____________________		

UNLESS SIGNED, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * ______________

NO, **DO NOT** DISCLOSE THIS INFORMATION * ______________

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient/facility receiving it, and would then no longer be protected by Federal privacy regulations.

I may revoke this authorization by notifying my provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that this authorization will expire on ____________________ OR 6 months from date of release. A photocopy of this form will be considered as valid as the original.

By signing below, I acknowledge that I have read and understand this Authorization.

*____________________________ ______________ ______________
Signature of Patient/Legal Guardian Relationship to Patient Date

***THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.**