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, _____ hereby authorize **MORE THAN JUST PODIATRY** to disclose my medical records as indicated below to:

_____
Name of Company/Provider/Individual

_____
Address **City, State** **Zip Code**

Specific information to be released:
____ Office Visits
____ Lab Reports
____ X-Ray Reports
____ Consult Reports
____ Operative Reports
____ Other _____

My purpose/use of the information:
____ Changing physicians
____ Continuing care
____ At my ( ) request
____ Workers' Compensation
____ 2nd Opinion
____ Legal
____ Insurance
____ School
____ 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 **More Than Just Podiatry** 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.

Federal/state laws permit a fee to be charged for the copying of patient records. Fee of $10.00 is to be paid at the time of collection. Based on HB 351, new maximum fees for copying will be $24.85 plus $0.57 per page for the cost of labor and supplies for copies provided in paper form and $23.26 for additional costs if records are maintained off-site. Based on HB 351, the new maximum fees for copying will be $24.85 plus $0.57 per page, or $108.88 total, whichever is less, for copies provided electronically.

_____	_____
Records Received By	Date
For Office Use Only	
Date Request Filled: _____	By _____
Patient Account # _____	
Photo ID Presented: _____	Fee: $25.00