Authorization for Release of Information

SPACE COAST
FOOT & ANKLE CENTER
Specializing in Medicine & Surgery of the Foot & Ankle

I hereby authorize John (Jack) MacKenney D.P.M dba Space Coast Foot & Ankle to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient_____ date of birth_____
(patient name) **(patient date of birth)**

This information is to be used/disclosed for the following purpose(s) only:

_____

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

(check one)

❑ Records for the following dates ONLY:_____to_____

❑ All records ❑ Other_____

This authorization will expire on _____
(state date or event)

To be released to:
(please indicate name/address of recipient)

_____

_____

_____

_____

Signature_____Date_____
(patient, parent or legal guardian)

Print Name_____

John (Jack) MacKenney D.P.M.
Fellow of the American College of Foot and Ankle Surgeons

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