

2700 Old Rosebud Rd, Suite 110  
Lexington, KY 40509  
www.lexpodiatry.com



Ph 859-264-1141  
Fx 859-264-1963  
happyfeet@lexpodiatry.com

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED MEDICAL RECORDS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize the use or disclosure of the medical records described below to be obtained by the following:  
*(Name and Address of individual or facility to receive records)*

\_\_\_\_\_  
\_\_\_\_\_

All health care records    X-rays    Lab results    Other \_\_\_\_\_

Only records of treatment on the following dates: From: \_\_\_\_\_ To: \_\_\_\_\_

This information will be obtained, used, or disclosed for the following purpose only:

Insurance    Continued Treatment    Legal    At the request of the patient or patient's representative

Other \_\_\_\_\_

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

I understand that I have the right to revoke this authorization, in writing, at any time. I also understand that a revocation is not effective when Lexington Podiatry has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim. To revoke an authorization, write a letter to Lexington Podiatry. I understand that this authorization will expire one year from the last date of services seen by this practice.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in the way on whether I sign this authorization or not.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_