

**ORTHOPAEDIC CENTER FOR FOOT AND ANKLE RECONSTRUCTION  
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION**

**\*\*Please Note: All of the following information must be completed in order to process this request.**

\_\_\_\_\_  
Print patient's full name

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
Street address

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
City, State, Zip code

\_\_\_\_\_  
Phone (Home) include area code

I, \_\_\_\_\_, authorize the facility name below,  
\_\_\_\_\_  
\_\_\_\_\_

to release my medical records as marked below, dates of service ALL, to:

**Orthopaedic Center for Foot and Ankle Reconstruction  
150 Kingsley Lane  
Norfolk, VA 23505  
Phone: (757) 889-6580/ Fax: (757) 889-6583**

\_\_\_ All clinical notes, except \_\_\_\_\_ All medical reports, except \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ All information, including attorney correspondence and financial, except \_\_\_\_\_  
\_\_\_\_\_

Purpose of Disclosure: \_\_\_ medical treatment / continuing care

\_\_\_ Other (please list) \_\_\_\_\_  
\_\_\_\_\_

I \_\_\_\_\_, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification, but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons, or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

\_\_\_\_\_  
Signature of individual or guardian or  
Personal representative of patient's estate

\_\_\_\_\_  
Date