Foot & Ankle® CLINIC
Dr. Jacqueline M. Babol
D.P.M., F.A.C.F.A.S.

Medical Records Request Form

I _____ (Patient Name), Date of Birth _____

Reason for request of records

_____Last chart note for continuation of care _____2nd opinion

_____Transfer of care to another doctor _____Personal (own records, lawyer, insurance)

_____Legal _____Other (please specify) _____

This request and authorization applies to : Dates _____ to _____

_____ ALL Healthcare information relating to the following treatment, condition or dates of treatment

_____ Xrays only _____Charts only _____Other _____

Records Requested FROM: Records to be released TO :

_____ _____

_____ _____

Address/ Fax Address/ Fax pls FAX TO

I understand that I may inspect the copy of the protected information to be used or discussed. I may revoke this authorization in writing by contacting your office. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and is no longer protected by HIPPA.

I understand that the information in my medical record may contain information relating to Sexually transmitted disease, HIV, AIDS, It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am

_____ (initial)AUTHORIZING _____ (initial) NOT AUTHORIZING the release of such information .

Signature of patient or patient's authorized representative DATE SIGNED

_____

Relationship or status if signed by anyone other than the patient (parent,legal guardian, personal representative etc)

This Authorization Expires 2 years from the date of signature.