13402 N. Scottsdale Rd
Ste B-185, Room 102
Scottsdale, AZ 85254

Phone: 480-247-6494
Fax: 480-247-6643

Authorization to Release Records

Name: _____ **Social Security #_____**

Address: _____

DOB: _____ **Phone Number: _____**

To/From: Name and address of Facility from which records are to be release/ requested:

Name: _____

Address: _____

Phone: _____ **Fax Number: _____**

To/From:
Sole Care Mobile Podiatry, PLLC
Rachel A. Janowicz, DPM, MPH
13402 N. Scottsdale Rd
Ste B-185, Room 102
Scottsdale, AZ 85254

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

_____ All Medical Records
_____ Medical Records from the last 2 years
_____ Permission to release Medical information, x ray results or test results to medical personnel only.
_____ Permission to release Medical information, x ray results or test results to patient or Family member.
Family Members name: _____ Relationship: _____
best way of contact: _____

_____ Permission to leave voicemail/ phone message. Phone #: _____

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I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

I understand the following: See CFR §164.508 I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Name and Relationship of Legal Representative to Patient

_____ _____

Witness Signature **Date**