DAVID B. GLOVER, DPM, FACFAS

MEDICAL INFORMATION RELEASE FORM

NAME: ______________________________ DATE OF BIRTH: _________________________

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination, rendered to me, appointment information, and claims information. This information may be released to:

Name:	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

☐ Information is not to be released to anyone.

I understand that

1. My records are protected and cannot be disclosed without written permission.
2. Once this facility discloses my health information by my request, it cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
3. I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 (164.524).
4. This authorization will remain in effect for one year or I provide a written notice of revocation to this facility.

This Release of Information will remain in effect until terminated by me in writing.

Signed: ______________________________ Date: ___________________________

Witness: ______________________________ Date: ___________________________