AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorization:

I hereby authorize Dr. Danita Reese her staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Patient name: _____ Date of birth: _____

Person/organizations receiving the information: _____

Specific description of information to be used or disclosed (including date(s):_____

Section B: Must be completed only if a health plan or a health care provider has requested the authorization.

1.The health plan or health provider must complete the following;

a. What is the purpose of the use or disclosure:

(no purpose need to be stated if the request is made by the patient and the patient does not wish to state the purpose)

b. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

Yes____ No_____

2.The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if do not sign this form. *Initials:_____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this form after I sign it.

*Initials: _____

Section C: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

The patient or the patients representative must read and initial the following statements.

1. I understand that this authorization will expire on 01/01/2020 *Initials:_____
2. I understand that I may revoke this authorization at any time by notifying Dr. Danita Reese in writing, but if I do it won't have any affect on any actions taken before receipt of my revocation.

*Initials:_____

Dr. Danita Reese will not condition my treatment on whether I provide authorization for the requested use or disclosure except (1) if my treatment related to research, or (2) health care services are provided to me solely for the purpose of creating protected heath information for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my doctor from a third party. [If applicable because the authorization is obtained for marketing purposes.]

*_____ Date_____

Signature of patient or patient's representative

Printed name of patient's representative (if applicable):_____

Relationship to the patient (if applicable):_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PATIENT INFORMATION SHEET

Do you have or have you had any of the following?

☐ Foot or leg injuries	☐ Diabetes	☐ HIV
☐ Foot or leg surgery	☐ Heart trouble	☐ Anemia
☐ Foot or leg cramps	☐ Epilepsy	☐ Bleeder
☐ Foot or leg numbness	☐ Liver disease	☐ Stomach ulcers
☐ Knee pain	☐ Kidney disease	☐ Blood disease
☐ Unequal leg length	☐ Rheumatic fever	☐ Bursitis
☐ Weak ankles	☐ Arthritis	☐ Polio
☐ High blood pressure	☐ Bunions	☐ Prone to infection
☐ Foot skin problems	☐ Toe nail problems	☐ Gout
☐ Fainting spells	☐ Asthma	☐ Cancer
☐ Circulation problems	☐ Varicose veins	☐ Hardening of arteries

Are you allergic or sensitive to:

☐ Novacaine
☐ Penicillin
☐ Adhesive tape
☐ Materials
☐ Drugs
☐ Foods
☐ Other (if so, describe) _____

List Medications

List Surgeries