Proactive Podiatry

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Authorization to Use or Disclose Protected Health Information

Patient's Name:	Date of Birth:
Address:	Phone:

I, _____, authorize Dr. Latika Hinduja to release my records to myself or to the following:

Provider's Name:	Phone:
Address:	Fax:

The records I am requesting are from the following dates:

_____

I am requesting these records because:

_____

I am authorizing the following information to be disclosed:

- o Physician Notes
- o X-Ray Reports
- o MRI Reports
- o Complete Records
- o Lab Results
- o X-Ray Disc
- o Cardiac Reports
- o Other: _____

Sensitive Information: I understand that the information in my record may include Personal Health Information (PHI) of all manners.

Redisclosure: I hereby authorize Dr. Latika Hinduja and office staff to release all the above information to me or to the provider listed above.

Patient (or Legal Guardian/Parent) Signature:_____