

DAVID W. MANSKY, D.P.M., PC.
AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Name: _____ Birthdate _____

I recognize that under the health insurance portability act of 1966 (HIPAA), I may limit the scope of information that I authorize to be disclosed (released).

LIST ALL limitation you have concerning what personal health information you do not want released:

() NONE

LIST ALL those people with which we are allowed to share your personal health information:

This applies to all information in my medical record protected under regulation in 42 code of federal regulations, part 2.

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I approve that my entire record released.

_____ I only approve my records be released from date of service _____ to date of service _____.

_____ I DO NOT approve that any of my records be released.

If deemed necessary by Dr. Mansky, I authorize this information to be sent via fax transmission, unless other wise agreed upon. Please sign here if you do not want any information faxed.

This release is effective for a period of one year unless other wise agreed upon. I may revoke my consent at any time by providing written consent to David W. Mansky, D.P.M., PC.

Signature of patient/guardian _____ Date _____