AMH Podiatry
love your feet
2705 Hospital Dr., Suite 212 Victoria, TX 77901

Authorization for Disclosure of Health Information

1. I authorize AMH Podiatry to disclose the following information from the health records of:

   Patient Name: _____ Date of Birth: _____

   Address: _____

   Telephone #: _____

   Covering the period(s) of health care: _____ All dates of Service or

   From (date) _____ to (date)_____

2. Information to be disclosed: ☐ Complete demographics and health record
   ☐ Discharge Summary ☐ History and Physical Examination ☐ Progress Notes
   ☐ Laboratory Tests ☐ Consultation Reports ☐ X-ray Reports
   ☐ Photographs, videotapes, digital, or other images
   ☐ Other _____

3. This information is to be disclosed to:

   Name/ Physician/ Facility: _____

   Address: _____Phone: _____ Fax: _____

4. The purpose of this disclosure is for: ☐ My personal records ☐ Sharing with healthcare providers
   ☐ Other: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to AMH Podiatry. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one year from today unless otherwise noted. If there are any questions please call us at 361-574-1857.

6. I understand that the information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. AMH Podiatry, its employees, officers, and doctors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent I have indicated and authorized.

_____ _____
Signature of patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of witness Date