Horizon

HORIZON FOOT & ANKLE
Division of HORIZON SURGICAL SPECIALISTS, P.A.

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MEDICAL RECORDS RELEASE/REQUEST FORM

(check one)

Release_____ Releasing information from us to you or your provider

Request_____ Requesting information from another provider to us

Date _____

Name _____ Date of Birth _____

Address _____

Phone _____ Social Security # _____

I authorize Horizon Surgical Specialists, PA to **release/request** the following:

Information Requested _____

_____

Purpose of Request _____

To / From (circle one) Name _____

Address _____

Phone and Fax _____

- I understand that this authorization may be revoked in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may NOT be re-released to any other person or organization without my written consent.
- I understand there may be a charge for medical records.

Signature _____ Date _____

Witnessed by _____ Date _____