Ritchie Steed, DPM, FACFAS
Flatirons Foot and Ankle Clinic
630 Coffman St. #A
Longmont, CO 80501
303-772-7008

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize Dr. Steed, to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

1. I grant permission to Flatirons Foot & Ankle Clinic to disclose health information of the following individual as specified below:

Patient Name:_____Date of Birth:_____

2. I authorize the information to be disclosed as specified below:

___On my voicemail at home_____(specify phone #)

___On my voicemail at work_____(specify phone #)

___On my voicemail on my cell phone_____(specify phone #)

___To the following person(s):

Name:_____DOB_____Relationship_____Phone #_____

Name:_____Relationship_____Phone#_____Fax#_____

___ Email (Not able to email test results, only confirmation of appts)_____

___ Do not leave any information on voicemail, attempt to contact directly

3. The type and amount of information to be disclosed is as follows: (please check appropriate options)

___Complete Medical record ___Progress Notes ___Prescription Drug Information

___X-rays ___Billing and Claim Records ___Medical Instructions or advice

___Laboratory ___Appointment information, including confirmation/cancellation of appointment

- I understand that this may include detailed personal medical information including medical services to be provided, as well as any information listed in #3 above.

Signature of Patient or Authorized Person Representative:_____

Date:_____

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