Long Island
Foot Care, P.C.
294 W. Merrick Rd., Ste 8
Freeport, NY 11520
T: 516-378-8383
F: 516-377-6991

I authorize **Long Island Foot Care, PC** to disclose the following information from the health records of:

Patient's Name: _____ DOB: _____

Address: _____ Telephone #: _____

_____

Covering the period(s) of health care:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

1. Information to be disclosed:
   - ❑ Complete health record

❑ Discharge Summary ❑ History and Physical Examination	❑ Progress Notes ❑ Laboratory Tests	❑ Consultation Reports ❑ X-Ray Reports

   - ❑ Photographs, videotapes, digital or other images
   - ❑ Other: _____
2. I understand that the information relation 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.
3. This information is to be disclosed to:
   Name & Address: _____
   _____
4. The purpose of this disclosure is for:
   - ❑ My personal records
   - ❑ Sharing with other healthcare partners
   - ❑ 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 **Long Island Foot Care, PC**. 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 on the following date, event or condition: _____.
6. **Long Island Foot Care, PC** 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.
7. I understand that I will be provided this information within 15 business days from receipt of request and I may be charged a fee for preparing and furnishing this information.

_____ _____

Signature of Patient or legal representative Date

If signed by legal representative, relationship to patient: _____

_____ _____

Signature of Witness: Date