

Authorization for Release of Information

I hereby authorize **Richard W Swails DPM PC dba McKinney Foot Care** 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, and that I will receive a copy of this form after I sign 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.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient _____ date of birth _____
(patient name) (patient date of birth)

This information is to be used/disclosed for the following purpose(s) only:

(no purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose).

<p>(check one)</p> <p><input type="checkbox"/> Records for the following dates ONLY: _____ to _____</p> <p><input type="checkbox"/> All records <input type="checkbox"/> Other _____</p>
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This authorization will expire on _____
(state date or event)

To be released to:
(please indicate name/address of recipient) _____

Richard W Swails, DPM
Bilal Master, DPM



5337 W University Drive
Ste 100
McKinney, TX 75071
p 972.542.3668
f 972.542.1728
mckinneyfootcare.com

Signature _____ Date _____
(patient, parent or legal guardian)

Print Name _____

Fax completed form to **972-542-1728**
or upload at www.mckinneyfootcare.com/sendfile