ADVANCED FOOT CARE OF NJ, LLC

Anant P. Joshi D.P.M
Podiatric Medicine, Surgery, Sports Medicine and Wound Care
1031 McBride Ave suite 105D, Woodland Park, NJ 07424
Phone: 973-256-0002 Fax: 973-256-3919
footpainnj.com

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name: _____ D.O.B: _____/_____/_____

I authorize the release of my medical records and information to the following people only:

☐ Self Fax / Email: _____

Family Member: _____ Fax / Email:_____

Particular Physician _____Fax / Email:_____

☐ To All my Physicians ☐ Third Party organization: Fax / Email:_____

Information to Be Disclosed:

☐ Entire Medical Record ☐ Labs / X-rays / Radiology Reports ☐ Other (specify): _____

I understand that my medical records or medical information may be released to another doctor deemed necessary by Advanced Foot care of NJ LLC for my continued care or my insurance company as requested.
I understand that I have the right to alter this authorization at any time in writing and addressed to Advanced Foot Care of NJ LLC. Any changes made to this authorization do not affect the records that have already been released.

I understand that any disclosure of information other than that to a doctor or insurance company may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment by Advanced Foot care of Nj LLC.
I understand that I may inspect and/or copy information to be disclosed. I understand that authorizing this disclosure is voluntary, If I have any questions about the disclosure of health information I may contact Advanced Foot Care of NJ.

I understand that the information release will include information that I entered on the forms for Advanced Foot care LLC, which may include drug abuse, surgeries, and medical conditions not related to my treatment by Advanced Foot care of NJ LLC.

_____ _____/_____/_____
Signature of Patient/ Authorized Representative: Date