DOC ON THE RUN
PODIATRY HOUSE CALLS

DR. CHRISTOPHER SEGLER
FOOT & ANKLE SURGEON
AWARD-WINNING EXPERTISE 24/7
(415) 308-0833

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Telephone Phone #: _____

Information to be Released To:
_____
_____
_____

From:
___Dr. Christopher Segler, DPM, San Francisco, CA
___Dr. Christopher Segler, DPM, San Francisco, CA
___Dr. Christopher Segler, DPM, San Francisco, CA

Please Release the Following:
_____ X-Ray Reports _____ History/Physical Exam _____ Clinical Progress Notes _____ Diagnoses
_____ Lab Reports _____ Other Diagnostic Reports (Specify) _____
_____ Other (Specify) _____

Including information (if applicable) pertaining to:
_____ Mental Health _____Drug/Alcohol _____HIV/AIDS _____Communicable Treatment

Purpose of Need for Disclosure:

_____ Insurance Claim/Application _____Continued Patient Care _____ Personal Use
_____ Attorney/Legal _____ Disability Determination _____ Other (Specify)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified. I will not hold Dr. Christopher Segler or Doc On The Run Podiatry House Calls liable for the actions taken by any insurance company, or agents acting on behalf of an insurance company, as a result of this disclosure.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Name Witness Signature

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold Dr. Christopher Segler or Doc On The Run Podiatry House Calls liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Name Witness Signature

Date request completed_____ # pages copied _____ Initials _____

236 WEST PORTAL AVENUE, SUITE #332, SAN FRANCISCO, CA 94127-1423
PH: (415) 308-0833 FX: (650) 993-8574

WWW.ANKLECENTER.COM