

MEMBER



American College of  
Foot and Ankle Surgeons  
Podiatric Physicians Providing  
Comprehensive Care

# Robert W. Sullivan DPM, PC

1700 Pleasure House Road, Suite 102

Virginia Beach, Virginia 23455

(757) 363-3338

Fax (757) 363-3453

Board Certified, American Board of Podiatric Surgery

Fellow American College of Foot and Ankle Surgery

## Authorization to Use or Disclose Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- I authorize the use or disclosure of the above named individual's health information as described below.
- Robert W. Sullivan D.P.M, P.C. is authorized to make the disclosure.
- The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated):

- entire medical record
- lab results (please describe the dates or types of lab tests you would like disclosed): \_\_\_\_\_
- x-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed): \_\_\_\_\_
- other (please describe): \_\_\_\_\_

4. I understand that the information in my health record may include information relating 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.

5. The information identified above may be used by or disclosed to the following individuals or organization(s):

Name:

Address:

Name:

Address:

6. This information for which I'm authorizing disclosure will be used for the following purpose:

- my personal records
- sharing with other health care providers as needed
- other (please describe): \_\_\_\_\_

7. 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 Robert W. Sullivan D.P.M, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): \_\_\_\_\_  
If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient : \_\_\_\_\_

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date

*Specializing in: Medical and Surgical Care of the Foot and Ankle  
Reconstructive Surgery of the Diabetic Foot • Advanced Wound and Ulcer Care*



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Date

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Signature of witness

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Date

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