Bay State Foot & Ankle Specialists, LLC
380 Lowell Street, Suite 102 Wakefield, MA 01880

HIPAA AUTHORIZATION FORM:
(The Notice of Privacy Practices for Protected Health Information can be viewed in detail. Please request an office copy for more detailed reading.)

I give permission to Bay State Foot & Ankle Specialists, LLC to:

- use the following protected health information, and/or disclose the following protected health information to:

Medical Insurance Companies, Physicians, Laboratory/Diagnostic/Therapy Services, Attorney, Workman's Comp, Human Resource, or other entities directly relating to my health care.

The above mentioned entities may receive the following Information:

- Medical Records
- Treatment Records
- Diagnostic Records
- Other: _____
  _____

This protected health information is being used or disclosed for the following purposes:

Releasing information to collaborate medical care with other medical institutions or physicians, releasing information to expedite payment for medical care with insurance companies, releasing information to update injury related cases.

This authorization expires in 6 years, unless otherwise indicated in writing.
If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.
You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.
Finally, you may revoke this authorization in writing at any time by sending written notification to Bay State Foot & Ankle Specialists, LLC 380 Lowell Street, Suite 102, Wakefield, MA 01880.
Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____
Patient/Guardian Signature Date

_____
Printed Name