AUTHORIZED COMMUNICATION FORM
For Use and Disclosure of Patient Health Information

I authorize **Winchester Foot & Ankle Associates PLLC** and any physician or other medical service provider who renders service to me to release to the physician treating me, insurance company, reimbursing agency, Valley Health affiliated entities, attorneys and others as allowed by the law whatever information, including a copy of, or electronic access to, my medical record for determination of benefits payable or for additional medical care information.

I give this office authorization to contact me directly at work or leave messages on my answering machine at home regarding my care.

□ Yes □ No Signature: _____

Please list any persons you would like to authorize to have access to your billing, appointment or health information such as your spouse, caregiver or family member. Proved SS#/DOB/Maiden Name of individual so we may identify the individual over the phone. And in the case of a minor, or those incapable of making their own medical decisions, please list below those individuals who can authorize care:

Name	**Relationship**	**Contact Number**	**SS#/DOB/Maiden name**

_____ _____

Date Patient/Guardian signature