Rocky Mountain Foot & Ankle

2667 E GALA CT. STE #130
MERIDIAN, ID 83642

PHONE: (208) 855-5955
FAX: (208) 459-8628

Authorization Form for Use & Disclosure of Protected Health Information (PHI)

Patient Name: _____
Date of Birth: _____
Social Security Number: _____

By signing this authorization form, I understand that I am giving the person(s)/organization(s) named below my authorization to disclose my protected health information (PHI) as described in more detail. (Please select specific information) to Rocky Mountain Foot and Ankle / P. Roman Burk, DPM, FACFAS.

Name of Person(s)/Organization(s): _____
Street Address: _____
City, State, ZIP: _____
Phone Number: _____
Fax Number: _____

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I further understand that I am entitled to receive a copy of this authorization.

- All Records
- Clinic/Outpatient Records
- Laboratory Reports
- Radiology Reports
- Pathology Reports
- Consultation Reports
- Other: _____

_____ _____
Patient Name (Print) Date

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient or Legal Authority if Applicable