

Consents for Information Exchange

I authorize InStride Coastal Carolina Foot & Ankle Care to use and disclose my protected health information (PHI) listed below.

\_\_\_\_\_\_Receive external prescription history (claims and dispense history provided by Surescripts)

\_\_\_\_\_\_Submit clinical information to Health Information Exchanges (Release of information)

Entity or person(s) authorized to receive this information:

\_\_\_\_\_\_Practice staff members only

This authorization shall be in force and effect until the time or event specified below, at which time this authorization expires.

\_\_\_\_\_\_Released from care \_\_\_\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice’s Security Officer at InStride Foot & Ankle Specialists. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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Signature of patient or personal representative Date

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Print name of patient or personal representative Relationship to patient (if not patient)