Allen Foot Doctors, part of StrideCare
Neha W Singh, D.P.M
1105 Central Expressway North Ste. 2300
Allen, TX 75013

Patient Authorization To Use and Disclose Protected Health Information (PHI)

Patient Name:_____

Address:_____ Home Phone:_____

City/State/Zip:_____ Cell Phone:_____

I hereby authorize the above named Practice (the "Practice") to use and disclose the following Protected Health Information ("PHI") (example: lab results, x-ray studies, information about your health condition and treatment):

Signature:_____

The above described PHI will be released to the following entities (example: spouse, children, other physicians):

_____ _____

_____ _____

The entities receiving this PHI may use it for the following purpose (example: general knowledge or treatment):

_____

I understand and acknowledge that:

1. The office ☐**will** or ☒**will not** receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

2. This authorization is voluntary and I may refuse to agree to its terms without affecting and of my rights to receive health care at the Practice.

3. This authorization may be revoked at any time by notifying the Practice in

writing at the above address to the attention “Privacy Officer.”

4. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

5. The information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.

6. My healthcare and payment for my health care will not be affected if I do not sign this form.

7. I may see and copy the information described in this form if I ask for it. And I can get a copy of this form, if I ask for it.

8. This form was completely filled in before I signed it, and I acknowledge that all of my questions were answered to my satisfaction, and that I fully understand this authorization form, and have received and executed this copy.

9. This authorization is valid as of the date I signed below and shall remain valid for a period of one year.

_____ _____

Name of Individual (printed) Signature of Individual Date

Witness:_____