

Release of Information

Southern Ohio Foot and Ankle Associates, Inc.
John F. Boyle, DPM
1130 Western Avenue
Chillicothe, OH 45601
740-775-7800 Office

Date_____

I hereby authorize Southern Ohio Foot and Ankle Associates, Inc. and/or its staff to disclose my individually identifiable health information. I understand this authorization is voluntary. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name_____ Date of Birth_____

Person(s) or Organizations(s) receiving information:

Information to be used or disclose should include, but not be limited to:

_____ X-Rays
_____ Office Notes
_____ All Medical Records

Signature of Patient or Patient Representative

Print name of patient or representative

Relationship to patient (if applicable)