Sharp Podiatric MEDICINE + SURGERY
John Sharp, DPM | Marc House, DPM

Sky Ridge Medical Center, Aspen Building
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Lone Tree, Colorado 80124
Office: 303.662.1600 | Fax: 303.662.1008

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________
Address: ____
City: ____________________ State: ________ Zip: ____________ Phone: ________________

I AUTHORIZE SHARP PODIATRIC MEDICINE & SURGERY TO RELEASE TO:

Name: ____
Relationship to Patient: ____
Address: ____
City: ______________________________ State: ____________ Zip: ______________
Phone: ____________________________ Fax: ______________________________

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORDS:

Please check the appropriate box (es):

☐Entire Medical Record, excluding X-rays
☐Entire Medical Record, including X-rays
☐X-rays only
☐Other: ____

NOTICE TO PATIENT

I understand that this consent is valid for 90days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to Sharp Podiatric Medicine and Surgery. I understand that after the custodian of records discloses my health information; it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature (Patient or Legal Guardian): ______________________ **Date:** ________________

CHARGES: The following charges apply to records copied for personal use, insurance, and attorneys.

Pages 10 or fewer: $16.50	Pages 11-40: $0.75 per page
Pages 40 and up: $0.75 per page	X-rays: $5.00 per X-ray

WE REQUIRE A MINIMUM OF FIVE BUSINESS DAYS AFTER RECEIPT OF SIGNED RELEASE TO PROCESS REQUEST