Advanced Foot and Ankle of Indian River
Amberly Paradoa, DPM, FACFAS Timothy Caballes, DPM, FACFAS Robby Caballes, DPM, AACFAS
3735 11th Circle 13852 US Hwy 1
Vero Beach, Florida 32960 Sebastian, Florida 32958
(772)299-7009

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By authorizing the listed persons below, they will have access to any and all of my health information, up to and including HIV, drug and alcohol and psychiatric records.

Amberly Paradoa, DPM/Timothy Caballes, DPM/Robby Caballes, DPM is permitted to share my medical information with them including test results, appointment reminders and information disclosed during office visits.

Patient: _____

Persons (other than Physicians) authorized to receive my medical information:

Name: _____

Relationship: _____

Phone: _____

Message: Yes _____ No _____

Name: _____

Relationship: _____

Phone: _____

Message: Yes _____ No _____

Name: _____

Relationship: _____

Phone: _____

Message: Yes _____ No _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Signature: _____ Date: _____/_____/_____

HIPAA: This organization complies with all HIPAA and other federal privacy regulations. A notice of privacy is available upon request. I acknowledge by signature below that I have been made aware of my right to review or obtain a copy of the policies.

NOTICE OF HEALTHCARE INFORMATION: All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as a necessary function of their role within the organization. This organization does not release patient records unless necessary for purposes of medical treatment, obtaining payment or supporting the day-to-day health care operations of the practice. Patient signature below provides the practice your consent to use and disclose my health information to the above statement.

Signature: _____ Date: _____/_____/_____