McLean County Foot and Ankle

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: EDUCATION

Patient Account #: _____
(To be completed by staff)

Patient Name: _____ **DOB**: _____ / _____ / _____
Last Name *First Name*

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

I, (Patient's name)_____, authorize McLean County Foot and Ankle to use my PHI (protected health information) and any imaging for educational and research purposes, including distribution of those recordings and information by any tangible of digital media (e.g. print, DVD, memory card, external storage device), or over the internet.

_____ I understand that I may be identified by name in any printed, digital, internet and I consent to the use of my
(Initial here) name and any other identifying information acquired as a result of my participation.

-OR-

_____ I do not consent to the use of my name. I understand that even though my name will not be used, it is
(Initial here) possible that someone may recognize me based on the images alone.

I understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already been released pursuant to this. If I want to revoke this authorization, I must do so in writing. The procedure for revoking this Authorization is to present my written revocation to McLean County Foot and Ankle.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. **It is possible that once disclosed, the privacy of this information may no longer be protected by federal and state privacy and security laws.** Unless revoked according to the above directions, this authorization will not expire.

I have read and understand the information in this Authorization form.

_____
Patient's Name (please print)

_____ _____
Patient Signature (or Personal Representative*) Date

_____ _____
Personal Representative's Name (please print) Relationship of Personal Representative

The Personal Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.