## McLean County Foot and Ankle

## **AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION: EDUCATION**

City: State: Zip Code:   City: State: Zip Code:   City: State:   Zip Code:   City:   Cit	Patient Accoun	* #·				
Street Address:  City:	ratient Account	-				
Street Address:  City:	Patient Name:		DO	OB:	/	/
City:					_ ,	· · ———
, (Patient's name)	Street Address	:				
ny PHI (protected health information) and any imaging for educational and research purposes, including distribution of the ecordings and information by any tangible of digital media (e.g. print, DVD, memory card, external storage device), or over internet.    I understand that I may be identified by name in any printed, digital, internet and I consent to the use of my name and any other identifying information acquired as a result of my participation.    OR-	City:	_	State:	Zip (	Code:	
(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 possible that someone may recognize me based on the images alone.  understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already be eleased pursuant to this. If I want to revoke this authorization, I must do so in writing. The procedure for revoking this Authorizatios to present my written revocation to McLean County Foot and Ankle.  have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosury as 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 that each of the information in this Authorization form.  Patient's Name (please print)	my PHI (protected ecordings and in	d health information) and any imag	ging for educational and res	search purposes	, including	g distribution of those
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	have read and u	nderstand the information in this Au	uthorization form.			
Patient Signature (or Personal Representative*)  Date	Patient's Name (ple	ease print)				
	Patient Signature (c	or Personal Representative*)	Date			

Relationship of Personal Representative

Personal Representative's Name (please print)

<sup>\*</sup>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.