



FOOT CARE PRACTITIONER  
2418 HWY 72/221 GREENWOOD, SC 29649  
P: 864-387-1116 FX: 270-220-0519  
WWW.STEPWRIGHT.COM

## Medical Release of Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

### I. My Authorization

I authorize the following using or disclosing party:

\_\_\_\_\_

**To use or disclose the following health information:** All my health information

**The above party may disclose this health information to the following recipient:**

Name: Moriah Wright, MSN, APRN, FNP-BC, CFCS

Organization: Step Wright, LLC

Address: 2418 Hwy 72/221 E. STE N, Greenwood, SC 29649

Fax: 270-220-0519

**The purpose of this authorization is:** At my request

**This authorization ends:** When I am no longer receiving care by Step Wright, LLC

### II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.



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I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_