

**RUTH ANN COOPER, DPM
4415B AICHOLTZ RD #200
CINCINNATI, OH 45245**

RELEASE OF INFORMATION

Patient Consent for Use and Disclosure of Medical Information For Payment or Treatment

The Practice recognizes the importance of patient privacy. As such, it is the policy of this Practice to treat all medical information as confidential and absent extraordinary or emergency circumstances, the Practice will not disclose a patient's medical information without appropriate patient consent.

I, as the patient, or authorized representative of the patient, consent to the release of information regarding services rendered by the Practice to my insurance company or any governmental payor of the medical expenses as listed, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, as listed by me, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of staff in caring for me. I consent to the Practice leaving a message on any answering device the Practice may reach when calling any telephone numbers I have provided, to confirm or change my appointment. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person(s) I have listed as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including, but not limited to, electronic mail ("email") and facsimile.

No original records or X-rays will be released from our office to any person or entity.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent the Practice has taken action in reliance upon my consent.

I acknowledge that I was provided a copy of the Notice of Privacy Practices #001 and that I have read (or had an opportunity to read if I so choose) and understood this Notice.

Patient/Parent/Guardian Signature: _____ Date: _____