DR. DUANE MCRORIE D.P.M.
CELEBRATION FOOT & ANKLE INSTITUTE
410 CELEBRATION PLACE STE 206 • CELEBRATION, FL 34747
2000 FOWLER GROVE BLVD • WINTER GARDEN, FL 34787
PHONE (321) 939-2001 • FAX (321) 939-2006

Patient Name:________________________________ Date of Birth:______________

Patient/Guardian Authorization

You may use or disclose the following health care information:

❐ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease Information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment, if any, unless specifically excepted: ___________________________________

❐ Other ____

You may disclose this health information to:

Name:_____________________________

Address:___________________________

Phone:____________________________ Fax:__________________________

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_______________________________________ _______________________________
Patient or legally authorized individual signature Date

_______________________________________ _______________________________
Printed name if signed on behalf of the patient Relationship (parent, legal guardian)