COMPREHENSIVE FOOT & ANKLE CENTERS

Christopher W. Hubbard, DPM Joshua R. Coger, DPM Samual P. Gracey, DPM

Westport Plaza
9407 Westport Rd., Ste. 110
Louisville, KY 40241
502.797.3338 (O)
502.919.7710 (F)

Jewish Medical Center South
1905 W. Hebron Ln., Ste. 204
Shepherdsville, KY 40165
502.797.3338 (O)
502.957.1731 (F)

HIPAA Release Form

Patient Name_____Date of Birth_____

Release of Information

☐ I authorize the release of information including diagnosis, records, examination rendered to me, and claims information.

This information may be released to the following people:

☐ Spouse _____
☐ Child(ren)_____
☐ Legal Guardian / Power of Attorney _____
☐ Other _____
☐ My information is not to be shared with anyone.

This release of information will remain in effect until terminated by me in writing.

Messages/Appointment Notifications

Please ☐ call ☐ text :

☐ my home (_____) _____-_____
☐ my work (_____) _____-_____
☐ my cell (_____) _____-_____

If unable to reach me (mark all that apply):

☐ you may leave a message with the person(s) I have authorized above for release of my information.
☐ you may leave a detailed message on my voicemail.
☐ please leave a message asking me to return your call.
☐ do not leave a message.

Signature_____Date_____