Consent for Release of Information/Records
To your Primary or Referring Doctor

Date ___/___/____ Patient's Name____
(First) (Last)

Social Security #_____- _____-_____

I hereby give my permission for Foot & Ankle Center of Arizona to release or disclose to:

____
(name of doctor, hospital ,agency, etc.)

This consent is subject to revocation at any time in the form of written notice from me, except to the extent that action has been taken in reliance thereon, or without revocation, will expire on ___/___/____ (this is not to exceed one year.)

Signature of patient:____ Date ___/___/____

Acknowledgement of receipt of notice of privacy practices

I acknowledge that I was provided a copy of the notice of Privacy which is located on the office website, and that I have read (or had the opportunity to read if I so choose) and understand the notice.

____
Print Name Date

____
Parent or Authorized Signature

I authorize the following people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name:____ Date of Birth:___/___/___

Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name:____ Date of Birth:___/___/___

Relationship to Patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other

May we leave messages regarding office and testing appointments on your answering machine?

☐ YES ☐ NO

Signed:____ Date: :___/___/___