

Prestige Podiatry

ACKNOWLEDGEMENT OF RECEIPT FOR THE NOTICE OF PRIVACY PRACTICES

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

Patient Name (please print)

Date

Patient Signature

Date

Parent or Authorized Representative (if applicable)

Date

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

I hereby authorize Prestige Podiatry to release information regarding myself contained in their records to the following people:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____