Feet First Podiatry/Raines Foot Clinic
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORAMTION TO FAMILY AND /OR CAREGIVERS

In the event Feet First Podiatry/Raines Foot clinic may need to give your test results or medical information, may we..... (Check all that apply)

_____ Leave a detailed message on an answering machine.
_____ Leave a message with your spouse or family member.
_____ Call you on your cellular phone, the number is _____
_____ Call you at work, the number is _____
_____ Speak to you directly. ONLY

I, _____ (DOB) _____, give Feet First Podiatry/Raines Foot Clinic doctor and or staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____
Name: _____Relatioship:_____Phone:_____

I understand that I have the right to revoke this authorization at any time. I understand that is I revoke this authorization I must do so in writing and present my written revocation to the Medical Records department.

I understand that the revocation will not apply to information that has already been shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and I need not sign this form in order to assure treatment. I understand that nay disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I was offered a copy of from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify a date **this authorization will expire one (1) year from the signature on this form.**

_____ Date_____
Signature of Patient

_____ Date_____
Signature of Guardian or Personal Representative

_____
Relationship to the patient