PODIATRY ASSOCIATES
OF FLORIDA, INC.
YANT DIVISION

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Podiatrist - Foot Specialist
Diplomate American Board of Podiatric Surgery

ACKNOWLEDGEMENT OF RECEIPT OF 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

_____
Parent or Authorized Representative (if applicable)

X _____
Signature

ALSO UNDER THE PRIVACY ACT WE NEED YOUR PERMISSION TO FILE MEDICAL CHARGES TO YOUR INSURANCE COMPANY. THIS ALSO GIVES US PERMISSION TO PROVIDE YOUR MEDICAL INFORMATION TO YOUR INSURANCE COMPANY AND ALL OTHER HEALTH CARE PROVIDERS IN RELATION TO YOUR TREATMENT.

PERMISSION IS ALSO GIVEN FOR THIS OFFICE TO LEAVE MESSAGES ON YOUR ANSWERING MACHINE OR WITH YOUR FAMILY MEMBERS.

_____
Name of Family Members to release your information to

X _____
Signature