# DOVER FOOT SPECIALTY CENTER, P.C.

## AUTHORIZATION FOR THE SHARING OF PROTECTED HEALTH INFORMATION

**NAME:**________________________________**DOB:**_________________________

**HOME PHONE #:**________________________

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**The providers/ staff of Dover Foot Specialty Center, P.C. have my permission to (Please check all that apply)**

| | |
|---|---|
| __Leave a message at home with my spouse or OK to pick up rx/samples with photo I.D. | Name:______________________<br>Relationship:__________________ |
| __Leave message on cell phone | Cell Phone #:__________________ |
| __Leave message at work | Work Phone#:__________________ |
| __Leave a message on voicemail | Phone #:_____________________ |
| __Leave a message on answering machine | Phone #:_____________________ |

**The providers/ staff of Dover Foot Specialty Center, P.C. may discuss my medical condition and /or history with:**

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| NAME | RELATIONSHIP |
|---|---|
| __________________________ | ____________________________ |
| __________________________ | ____________________________ |

**If I DO NOT WANT** certain information about me disclosed, I will list it below:

____________________________________________________________________

____________________________________________________________________

| | |
|---|---|
| ______________________________ | ______________________________ |
| Patient Signature<br>(Parent/ Legal Guardian, or Appropriate Consenting Party) | Relationship/ Date |

**EXPIRATION:** This authorization expires no later than one year from the date it was signed.

**THIS CONSENT MUST BE MAINTAINED FOR 6 YEARS**

**INITIAL OF PERSON TAKING REQUEST:**___________