About Feet
PODIATRY CENTER & AFP SURGERY CENTER

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Authorization for Communication & Disclosure of Medical Information

Patient Name: _____

Date of Birth: _____

1. Authorized Individuals

I authorize the following individual(s) to receive information regarding my medical care (including appointments, billing, lab/test results, or treatment plans):

Name	Relationship	Phone/Email	Type of Info Allowed
_____	_____	_____	Appts / Results / Billing / All
_____	_____	_____	Appts / Results / Billing / All

2. Communication Preferences

Please CIRCLE the communication methods you allow and CROSS OUT any methods you do not want us to use:

Phone Call

Voicemail (message may include medical details)

Text Message

Email

U.S. Mail

3. Privacy Acknowledgement

- I understand that once information is disclosed to an authorized individual, it may be subject to re-disclosure by them.
- I understand that I may revoke or change this authorization at any time by submitting a written request, except to the extent that action has already been taken.
- This authorization does not expire unless revoked in writing.

Patient Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature (if patient is a minor): _____

Witness: _____ Date: _____/_____/_____