Healthy Feet Podiatry

Authorization to Share Protected Health Information

Patient Name

I authorize the physicians and staff of:

Healthy Feet Podiatry

To share protected health information with the following persons:

_____ Relationship_____

_____Relationship_____

_____Relationship_____

This includes (please check all areas that apply)

- All Medical Information
- Lab Results
- Medication RX renewal & Pickup
- Telephone Consults
- Insurance Information
- Appointment Information
- Other (please specify

This authorization will be in effect until authorization is revoked.

Patient's signature_____ Date_____