PodiatryCare, P.C. *and the* Heel Pain Center

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American Board of Foot and Ankle Surgery
Dr. Charlotte G. George
Dr. Rebecca M. Wiesner
American Board of Foot and Ankle Surgery

Authorization for Release of Information to Family Members

Patient Name:_____ Date of Birth: _____ Acct #: _____

Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form.

I authorize **PodiatryCare, P.C.** *and the* **Heel Pain Center** to release my medical and/ or billing information to the following individual(s):

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclose by the above recipient.

You have the right to revoke this consent in writing.

Patient Signature: _____ Date: _____