ARCH PODIATRY ASSOCIATES, PA
Patient Authorization Form

Patient Name _____

Patient's Social Security Number _____

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled. You may request a copy of the policy from our staff. Please read each authorization carefully and indicate your approval by signing on the lines provided.

I authorize the release of all medical records maintained by **Arch Podiatry,** which relate to services I have received from, or the results of tests ordered by **Arch Podiatry**. These records may be released as needed for my care, for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipated litigation under a worker's compensation, motor vehicle accident, and /or third party liability claim.

_____ _____
Accept – Initial Decline – Initial

I authorize direct payment of benefits from my insurance plan to **Arch Podiatry**. I understand that I am responsible for payment of professional fees charged by **Arch Podiatry**, which are not covered, or not properly reimbursed under the terms of my insurance plan.

_____ _____
Accept – Initial Decline – Initial

I will provide **Arch Podiatry** with the phone numbers I authorize **Arch Podiatry** to use to contact me. I authorize the use of any messaging person or system, voice mail, and /or an answering machine to convey information regarding my care.

_____ _____
Accept – Initial Decline – Initial

I authorize the use of Faxing or E-mail to send my information to myself or to other parties that have a right to receive my information. I understand that every effort is made to protect my privacy, however, no absolute privacy guarantee is given when Faxing or E-mail is used.

_____ _____
Accept – Initial Decline – Initial

I understand that it is my right to request that others have limited access to my records and to withdraw permission for the release of my records to others. I understand that this request must be in writing and that limiting or withdrawing my permission may result in Arch Podiatry discontinuing its relationship with me and that I will need to seek care from another source.

_____ _____
Accept – Initial Decline – Initial

I have elected to keep a copy of the Arch Podiatry Notice of Privacy Policy for my own records.

_____ _____
Accept – Initial Decline – Initial

The following people may have access to my records:

_____

_____ _____
Signature – Responsible Party Date