PODIATRY ASSOCIATES, P.C.

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PERMISSIONS

I hereby give my permission for Dr. Cynthia Oberholtzer-Classen, DPM or Dr. Adam Toren, DPM or Dr. Chelsea Farrington, DPT or Dr. Kristina Calabrese, DPT, to release any necessary information, including but not limited to: office notes, lab/test results, operative reports, etc. to my primary physician, any specialist I am being referred to, or any outpatient facility that may require my personal or medical information (i.e. physical therapy facility, outpatient surgery centers, radiology facilities, etc.).

I authorize Podiatry Associates, PC; Castle Pines Physical Therapy, PC to furnish a copy of medical or other information of any claims under Title XVIII of the Social Security Act and its intermediaries, or to an authorized person.

I understand that if I am seen on a referral, the physician may require the treatment notes to be sent to them in order to extend or renew my referral.

I authorize treatment for services rendered and ordered by the physician or physical therapist.

X_____ Date: _____

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to Podiatry Associates, P.C. I acknowledge that I am financially responsible for payment whether or not the procedure is covered by my insurance.

X_____ Date: _____

NOTICES OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices or was given the opportunity to read the Notice of Privacy Practices and understand the notice.

X_____ Date: _____

CONFIDENTIALITY POLICY

I understand that all health information that I have disclosed or will be discussed in office visits with the doctor or physical therapist is confidential and can only be released with my permission.

I give my permission to speak with and give detailed information with the name of the person provided below and give permission for detailed messages to be left at the number provided below.

Name: _____ Relationship: _____

Phone number: _____

X_____ Date: _____