Valley Podiatry Associates, P.C.
Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have been provided/offered a copy of Valley Podiatry Associates, P.C. ***Notice of Privacy Practices*** and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

SIGNATURE OF PATIENT /GUARDIAN _____ D. O.B. _____

PATIENT PRINTED NAME _____ DATE _____

Designation of Personal Representative
At my request, I hereby name the following individual as my personal representative and authorize my PHI be released to him/her:

AUTHORIZED PERSONAL REPRESENTATIVE _____ RELATIONSHIP TO PATIENT _____

AUTHORIZED PERSONAL REPRESENTATIVE _____ RELATIONSHIP TO PATIENT _____

***Information can not be given to your emergency contact unless they are listed here.