RNV Podiatry
FOOT AND ANKLE SPECIALISTS

CONSENT TO RELEASE HEALTH INFORMATION

I understand that in order to disclose my Protected Health Information, RNV Podiatry must have my consent. Therefore, I authorize RNV Podiatry to disclose my Protected Health Information as described on this form, to the recipients listed below: Description of the information to be disclosed (check all that apply):

All Procedures _____ Test Results _____ Appointments _____

Other _____ Surgeries _____ Billing/Account Information _____

Name(s) of the person(s) authorize to obtain the above-mentioned information. Example: physician other than your referring doctor, family members, other specified person(s).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name (Print) _____

Signature _____ Date ____ /____ /____