Achilles Podiatry Group

8651 Township Line Road Indianapolis, IN 46260

ACKNOWLEDGEMENT OF RECEIPT FOR THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) *Date*

_____ _____

Patient Signature *Date*

_____ _____

Parent or Authorized Representative (if applicable) Date

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

I herby authorize Achilles Podiatry Group to release information regarding myself contained in their records to the following people:

Name:_____

Name:_____

Name:_____

Name:_____

Name:_____