Andrew Cassidy, DPM

Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Andrew Cassidy, DPM, reserves the right to change their Notice of Privacy Practices. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Andrew Cassidy, DPM to share my protected health information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I wish to be contacted in the following manner:

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone

Ok to leave message with detailed information?

- ☐ Yes ☐ No
- ☐ Yes ☐ No
- ☐ Yes ☐ No