ACKNOWLEDGMENT OF RECEIPT
OF
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

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Would you like to give Instep Podiatry, LLC permission to discuss your medical records and/or financial information to another person other than yourself? This can include, but is not limited to your spouse or another family member who might need to ask questions about your account. Please list the name(s) and relationship below.

_____
_____
_____

I give the person (s) listed above to receive information on my behalf from Instep Podiatry. I do understand, I can revoke this permission granted at any time via written format to file in my chart for documentation purposes.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature