Francis J. Clark, DPM
Clay B. Shumway, DPM

PATIENT PRIVACY AUTHORIZATION

Name of Patient:_____Date of Birth_____
(Please print)

I request that all communications to me (by telephone, mail, or otherwise) by Francis J. Clark, DPM, Dr. Clay B. Shumway and/or staff be handled in the following manner:

- For written communications:

  Address to:_____

_____

- For oral communications:

  Call: _____
  (Telephone Number)

Confidential messages (i.e. lab reports, x-ray results, appointments, etc.) may be left.

Please *circle all* for which you grant consent: **home answering machine / Voicemail / Family member**

Please list any family member(s) or other person(s), if any, whom we may inform about your general condition and your diagnosis:

_____

Please list the family member(s) or significant others, if any, whom we may inform about your medical condition in an emergency **(if different from above.)**

_____

_____

Please list any other pertinent information you think this office should know regarding your privacy.

_____

I am aware that a cellular phone is not a secure phone line.

I acknowledge that I have had the opportunity to read the Notice of Privacy Practices/HIPAA and understand it fully.

I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____

(Print Name) (Signature) (Date)