FOOT HEALTH CENTER

Dr. Thomas H. Walter, DPM

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(860) 599-4555 Phone
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Client Name: Last First M.I. DOB

CONSENT AND ACKNOWLEDGMENT FORM

I consent to the use or disclosure of my protected health information by Foot Health Center to any person or organization for the purposes of carrying out treatment, obtaining payment, or conducting certain healthcare operations. Protected health information used or disclosed by Foot Health Center may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that this consent is effective for as long as Foot Health Center maintains my protected health information.

By signing below, I understand and acknowledge the following:

I have read and understand this consent.

Print name of individual or Personal Representative

Signature of individual or Personal Representative Date

If signed by individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence/other medical reason
- ☐ Other: _____