ROBERT T. SPALDING Jr., DPM

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Due to **HIPAA (Privacy Act)**, we are requesting that the patient please complete this information sheet prior to being seen by Dr. Spalding or his associates of Area Podiatry. Please check the appropriate box.

1. I [ ] do or do not [ ] authorize a message to be left either on an answering machine or with whomever may answer the phone. Otherwise, I authorize this decision be left to Dr Spalding's discretion.

2. I do [ ] do not [ ] authorize release of medical information to outside sources such as insurance carriers, home health agencies, and workman's compensation plans. Please list the names of your insurance company (s), home health agency, and workman compensation plan otherwise I authorize this decision be left to Dr. Spalding's discretion.

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3. I [ ] do or do not [ ] authorize release of medical information to any laboratory or facility for which diagnostic tests are requested by my physician. Please list the lab that you wish to use otherwise, I authorize this decision be left to Dr Spalding's discretion.

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4. I [ ] do or do not [ ] authorize release of prescription information to my pharmacy. Please list the pharmacy (s) that you wish to use otherwise, I authorize this decision be left to Dr Spalding's discretion.

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5. I [ ] do or do not [ ] authorize release of medical information to my designated caregiver. This includes the person who may be used to pick up written prescription or orders for testing. Please specify the name of the person or persons as well as the relationship to you. Otherwise, I authorize this decision be left to Dr Spalding's discretion.

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6. I [ ] do or do not [ ] authorize release of medical information to Southeastern O&P, A&R Orthotics, J&S Shoes, Fillauer O&P, Fast Break Shoes, Front Runner Shoes if requests for shoe inserts, orthotics, braces or shoe gear be initiated by Dr. Spalding. Otherwise, I authorize this decision be left to Dr Spalding's discretion.

7. I [ ] do or do not [ ] authorize acquiring pictures and the release of pictures of my foot pathology to be used between physicians, in educational settings, seminars, books or other printed material to increase the knowledge base of this profession, related professions, or general public and I do not seek compensation for such allowance.

I, ______________________________ being the patient above have completed the above and checked the appropriate boxes and completed the appropriate information. I fully understand that this guideline will be strictly enforced. I am fully aware that if any information needs to be changed that I will need to complete a new form. Furthermore, I realize that if I do not designate a specific pharmacy then I will not be able to receive prescription call-ins. Also, I realize that if I have not designated a specific person to pick up my medical information then Dr. Spalding cannot give records to any family member. I fully realize that if I do not authorize pictures of my feet, Dr. Spalding will be unable to document my foot pathology and Dr. Spalding reserves the right to not treat me for his protection. Finally, I acknowledge that I do not wish for information to be released to insurance companies or workman's compensation plan that I will be personally responsible for the amount due.

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Signature of Patient (Cannot be completed by a caregiver or staff member) **DATE**