Dear Patient,

In order to protect your confidentiality and to comply with government regulations (HIPAA), Dr. Robert Bondi, Dr. Laurel Bondi and Dr. Ann Hanon are required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:
The physicians and staff at the Foot Doctors of KC office may discuss my medical information and/or care with the following. **(Please check all that apply and list the names.)**

☐ My Spouse (name)_____

☐ Name_____ Relationship_____

☐ Name_____ Relationship_____

MESSAGES:
I give my consent to the physicians and staff of the Foot Doctors of KC office to leave or discuss treatment, surgery, lab, radiology results or other information regarding my care as follows.
(Please check all that apply.)

☐ On answering machine or voice mail at home.

☐ On cell phone

☐ On answering machine or voice mail at work.

☐ Email through Patient Portal

☐ I do not consent to messages being left at home, work, or with any other person.

I hereby acknowledge that I have received Robert Bondi, DPM, Laurel Bondi DPM and Ann Hanon DPM Notice of Privacy Practices. (HIPAA)

Patient's Name: _____ Date of Birth:_____
(Please print)

Signature: _____ Today's Date:_____
(Patient sign *or* Parent of a minor)

HIPAA CONSENT TO VIEW HISTORY OF SCRIPTS:

I also give consent to Drs. Robert Bondi, Laurel Bondi and Dr. Ann Hanon to view my prescription history.

Signature: _____ Today's Date: _____
(Patient sign *or* Parent of a minor)