DR. IVAN J. NOSACEK, P.A.
Board Certified

FAMILY FOOT CARE

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Medical Information Disclosure to Family/Friends

___ I authorize Provider and Provider's staff to disclose information related to my care, treatment and billing to the following name individual(s):

Name _____ Phone Number(s) _____

Relationship (to me) _____ Address _____

Name _____ Phone Number(s) _____

Relationship (to me) _____ Address _____

Patient Name (printed) _____ Signature of Patient (or legally responsible individual) _____ Date _____

Witness _____ Date _____

SCANNED TO PATIENT PERMANENT RECORD _____ Date

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