



Standard Authorization of Use & Disclosure of Protected Health Information

Robert C. Schulte, DPM
 Chad M. Knutsen, DPM
 Michael J. Burns, DPM#

Patient's Name _____ Date _____

The above named patient has authorized us to request the following information:

- _____ Request X-rays
- _____ Request Pertinent Records
- _____ Request Laboratory Results
- _____ Other (please explain) _____

Board Certified:
 American Board of Podiatric Surgery
 #Am. Board of Podiatric Orthopedics
 Members:
 American Podiatric Medical Assn.
 Colorado Podiatric Medical Assn.
 Fellows:
 Am. College of Foot & Ankle Surgeons
 #Am. Academy of Podiatric Sports Med.

—  —
 Soothing, effective treatments for:
 Flat feet, high arches, heel pain, bunions & hammertoes
 Ankle sprains, fractures & chronic pain
 Nail problems
 Infant deformities
 Sports injuries & prevention
 Corns & calluses
 Diabetic foot care
 Nerve problems
 Skin problems
 Warts

From the following Person(s):

Name of person(s) or organization

Name of person(s) or organization

Address, City & State

Care that fits your schedule:
 Early morning, lunchtime & evening hours
 Same-day appointments
 Major insurances & credit cards accepted

Expiration Date of Authorization
 This authorization is effective through _____ unless revoked or terminated by the patient or the patient's personal representative.

Potential for Re-disclosure
 Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient _____

2001 South Shields, Bldg. F
 Spring Creek Medical Park
 Fort Collins, CO 80526
 970-493-4660
 Fax 970-493-6710

Signature of Patient _____ *Date*

Signature of Patient Representative _____ *Date*

Relationship of Patient Representative to Patient _____

3850 N. Grant Ave., Suite 130
 Loveland Medical Plaza
 Loveland, CO 80538
 970-667-0769
 Fax 970-667-3389