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

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

Care that fits your schedule:

Early morning, lunchtime & evening hours
Same-day appointments
Major insurances & credit cards accepted

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

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

Web Site: www.asafoot.com

Standard Authorization of Use & Disclosure of Protected Health Information

Patient's Name ______________________ Date __________

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

_____ Release X-rays

_____ Release Pertinent Records

_____ Release Laboratory Results

_____ Other *(please explain)* ______________________

____

If originals, they are to be returned within 30 days of the above date ________

To the following Persons to Whom Information May Be Disclosed:

____
Name of person(s) or organization

____
Name of person(s) or organization

____
Address, City & State

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 ______________________________

______________________________ ____________
Signature of Patient *Date*

______________________________ ____________
Signature of Patient Representative *Date*

Relationship of Patient Representative to Patient ____________________