

**PACIFIC PODIATRY GROUP**  
Foot & Ankle Care | Surgical Disciplines

**COMMUNICATION AUTHORIZATION – *Please Complete***

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place a check (✓) in the appropriate box(es). If you would like us to notify you of your appointments via email, please give us your email address.

- Home     message to return call     detailed message (results, treatment)     NO message  
 voice mail     with an individual

Phone Number \_\_\_\_\_

- Work     message to return call     detailed message (results, treatment)     NO message  
 voice mail     with an individual

Phone Number \_\_\_\_\_

- Cellular     message to return call     detailed message (results, treatment)     NO message  
 voice mail     with an individual

Phone Number \_\_\_\_\_

In certain instances, it may be necessary to communicate via email.     YES email     NO email

If Yes, email address \_\_\_\_\_ @ \_\_\_\_\_ .com

**RELEASE OF INFORMATION POLICY – *Please Read***

I hereby authorize Pacific Podiatry Group to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s).

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to patient \_\_\_\_\_

If this information is not completely filled out, Pacific Podiatry Group will not release information to anyone listed above.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_