Chart #_____

Canonsburg Podiatry Associates
Consent to Disclosure of Personal Health Information

I, the undersigned individual, give my permission to the practitioners and staff of **Canonsburg Podiatry Associates** to release information regarding my care, including my medical condition, test results, and appointment dates and times to the following individuals:

Name	Relationship	Phone Number

Please Check All That Apply:

_____ I give my permission to the practitioners and staff of **Canonsburg Podiatry Associates** to leave information regarding my care, including my medical condition, test results, and appointment dates and times on the modalities listed below:

Answering Machine _____
Office Voice Mail _____
With Another Person _____
Via Mail _____
Via e-mail _____ E-mail address_____
Cell Phone _____ Number_____

_____ I also give my permission to the office staff to acknowledge my presence in the office should an inquiry be made.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____
Relationship To Patient

_____ _____
Staff Initials Date