



Westside Podiatry Group, LLC

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PATIENT PRIVACY AUTHORIZATION

1. Please list any family members or other person(s), if any, whom we may inform about your general condition and your diagnosis:

2. Please list the family members or significant others, if any, whom we may inform about your medical condition in an emergency (if different from above).

3. May confidential messages (i.e. lab reports, X-ray results, appointments, etc) be left on your home answering machine, voicemail or with family members? Please check all for which you grant consent.

4. May we call you at work? Yes No

5. If necessary, may we fax your protected health information to another doctor's office, insurance company, employer, pharmacy, school, attorney, town offices (handicap parking), nursing/resident home? Yes No. Please be advised that checking "No" may lead to significant delays in important communications regarding your health care.

6. Please list any other pertinent information you think this office should know regarding your privacy.

7. I am aware that a cellular phone is not a secure phone line.

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Print Name

Signature

Date

GREECE OFFICE
2236 RIDGE ROAD WEST
ROCHESTER, N.Y. 14626
(585) 225-2290
FAX (585) 225-1367

GATES-CHILI OFFICE
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ROCHESTER, N.Y. 14624
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919 WESTFALL ROAD
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