ADVANCED FOOT and ANKLE SURGEONS, LLC
COMMUNICATION AUTHORIZATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ **Social Security Number** _____

I authorize the providers and staff of Advanced Ankle and Foot Surgeons, LLC to discuss and disclose my Protected Health Information (PHI) to the person(s) named below.

Name	Relationship	Phone Number

I authorize the providers and staff of Advanced Ankle and Foot Surgeons, LLC to leave messages:

☐ _____ Initials — On my **home** answering machine / voice mail. _____ Phone Number

☐ _____ Initials — On my **cell phone** voice mail. _____ Phone Number

---

HIPAA: NOTICE OF PRIVACY PRACTICES

I have received, and/or been provided the opportunity to receive, a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared.

I acknowledge that the Advanced Ankle and Foot Surgeons, LLC physicians, medical assistants and other staff may use and share my confidential health information with others in order to 1) treat me, 2) to arrange for payment of my bill, and 3) for issues that concern Advanced Ankle and Foot Surgeons, LLC operations and responsibilities.

This authorization remains in force until revoked in writing. The purpose of this disclosure/use is for continued medical care.

_____ _____ _____
Signature of Patient, Guardian, Personal Representative Relationship Date

_____
Print name of person authorized under state law to act in the patient's behalf, if the patient is deceased, or his personal representative, or if none, of his child, parent or sibling.