# Authorization to Treat/ Acknowledgement of Receipt of HIPPA Privacy Notice

**Authorization to Treat:**

I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees
- Voluntarily and without compensation authorize Arches Foot and Ankle Clinic to take and use pictures and/or videos of my foot for educational and advertising purposes.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intent this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Arches Foot and Ankle Clinic to furnish information to insurance carriers concerning my illness and treatment.

**Acknowledgement of Receipt of HIPPA Privacy Notice:**

In accordance with HIPPA, I have had the opportunity to read and receive a copy of the Privacy Practices located in the office of Arches Foot and Ankle Clinic. I understand my information will be used for the purpose of treatment, payment and healthcare operations.

**NOTE: Original x-rays are the property of this office. Copies may be purchased for $5.00 each.**

A photocopy of this consent shall be considered as valid as the original.

**Release of Information to Family Members:**

I authorize/allow Arches Foot and Ankle Clinic to release my medical and/or billing information to the following individual (s):

1. _____Relation to the Patient_____
2. _____Relation to the Patient_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Patient/Guarantor Signature:**_____**Date:**_____