Allegheny Podiatry Management, L.L.C.
495 East Waterfront Drive, Suite 230
Homestead, PA 15120
412/461-1108

PATIENT CONFIDENTIALITY FORM

Patient Name _____ Date of Birth _____

Please check the appropriate box(s).

o We MAY inform the following family members or other persons about your general medical condition and your diagnosis:

_____

o List the family members or other persons, if any, who **ARE NOT** authorized to pick up on your behalf, healthcare information such as medical records, prescriptions, test results, etc.:

_____

Upon request, I was provided a copy of the Notice of Privacy Practices and I acknowledge that I have read (or had the opportunity to read if I so chose) and understood the Notice as well as the above Patient Confidentiality Form.

_____ _____
(please print) Patient Name Date

_____ _____
Signature Parent or Authorized Representative (if applicable)