VILLAGE PODIATRY CENTERS
EXCELLENCE IN FOOT & ANKLE MEDICINE

Authorization to Discuss Medical Information

Patient Name: _____ DOB: _____

I give Village Podiatry Centers and its' departments/employees, permission to verbally discuss my medical information with the following person(s). This is not an authorization to release medical records.

Name	Relationship

Medical information may include: diagnosis, treatment, and billing related items

I must notify Village Podiatry Centers in writing if changes are needed. A new form must be filled out. The form with the most current effective date will be active.

This authorization is good until _____ or, if no date given, when changed in writing by me.

_____ _____ _____

Signature Effective Date Time

Patient gave verbal consent:

_____ _____ _____

Witness Signature Effective Date Time

_____

Print Name (Witness)