CARROLLTON
FOOT CENTER

CONSENT FOR TREATMENT

I give my consent to be treated by Carrollton Foot Center, PLLC. I understand that this is a general consent, and that if I am to receive any specialized treatment, I will sign the appropriate informed consent form prior to receiving that service.

AUTHORIZATION FOR RELEASE OF INFORMATION

I/we authorize Carrollton Foot Center, PLLC to release medical, psychiatric and substance abuse information contained in my/the patient's records to insurance carrier(s), physicians or other healthcare practitioners. Unless noted below, medical records released may include diagnostic and therapeutic information (including test for HIV antibody/substance abuse).

Withhold from release: (please specify if any):

_____

Information is disclosed from records whose confidentiality is protected by Federal and State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal/State law.

Please list the **names** of any other people your medical records and information may be provided to (i.e. spouse, parent, caregiver, etc):

Name:_____ Relationship:_____ Phone:_____

By signing below, I acknowledge that I understand the information on this document. I also permit a copy of this to be used in place of the original.

_____ _____

Patient/Guarantor Signature Date

Carrollton Foot Center, PLLC

Phone: (469)998-3668
Fax: (469)444-6065
info@carrolltonfeet.com

4221 Medical Pkwy Suite 450
Carrollton, TX 75010