Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breech of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish Carolina Podiatry Group, Inc. to be able to discuss my medical condition. I understand this form will be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Carolina Podiatry Group, Inc. in writing of my decision. In accordance with the above, I

____, hereby authorize

Carolina Podiatry Group, Inc. to discuss with and release my medical information to the following individuals:

______________________________ ________________________________

______________________________ ________________________________

________________________________ ______________
Patient Signature **Date**

________________________________ ______________
Witness **Date**

Revised 8/2/2013