SURGICAL FOOT SPECIALITIES, P.A.

Deryck R. Fernandez, D.P.M.

Foot & Ankle Surgeon

CONSENT TO TREATMENT AND AUTHORIZATION

I _____ (print full name) authorize providers of Surgical Foot Specialties, P.A. to treat me for my health, wellness and routine primary care management. I authorize Dr. Deryck Fernandez and his designees to perform routine examination, order or perform diagnostic or laboratory tests, or routine procedures pertaining to my care. I acknowledge that no guarantee or assurance has been made to me regarding the result of any examination or treatment.

In the event of a medical emergency, I authorize Deryck Fernandez, D.P.M. and his designees to provide necessary emergency care.

I acknowledge that medical and other Information relating to me will be accessible to all Deryck Fernandez,·D.P.M. health care professionals or consultants participating In my care or treatment and I grant full discretion In determining what Information Is necessary to be divulged to those participating in my care of treatment.

I acknowledge that radiology interpretation and laboratory services are provided through an independent contracting arrangement and that Deryck Fernandez, D.P.M. assumes no responsibility for the services I receive therefrom.

Dr. Fernandez and his designees make every attempt to protect your confidentiality. I acknowledge that providers at surgical Foot Specialities, P.A. may need to share information about me and my medical condition to other health care providers and consultants, and I hereby give Deryck Fernandez, D.P.M. full discretion in determining what medical information may be released for the purposes of treatment, payment, and healthcare operations.

Surgical Foot Specialities, P.A. providers reserve the rights to share medical records for routine purposes. The release of information is applicable to all medical information that may pertain to the treatment of drug and/or alcohol abuse or for psychiatric and/or mental conditions or for AIDS/HIV. As a public safety measure, providers may make my medical record available to public health agencies that track Infectious diseases and notify at-risk Individuals. I understand that Surgical Foot Specialities, P.A. may become obligated to make available medical records to criminal or civil courts pursuant to legal process. I am also advised that mental health intervention and treatment will not be disclosed unless the provider or mental health professional treating me determines that there is a compelling need for disclosure based on a substantial probability of harm to self or others.

I acknowledge that data from my patient records will be accessible tor utilization review for the purpose of quality management and improvement, peer review and performance improvement.

I acknowledge that I have been given the Notice of Privacy Practices I understand that if I have questions or complaints that I should I contact the Privacy Official. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

CONSENT WILL REMAIN IN FORCE UNTIL REVOKED IN WRITING OR UNTIL MINOR IS 18.

Patient's Signature _____ Date _____

Parent/Legal Guardian signature (if applicable) _____ Date _____

Emergency Contact Name _____ Phone# _____

Name of person we may share health Information with _____

Phone# _____