



Standard Authorization of Use & Disclosure of Protected Health Information

Robert C. Schulte, DPM
 Chad M. Knutsen, DPM
 Michael J. Burns, DPM#

Patient's Name _____ Date _____

The above named patient has authorized us to release the following information:

- _____ Release X-rays
- _____ Release Pertinent Records
- _____ Release Laboratory Results
- _____ Other (please explain) _____

Board Certified:
 American Board of Podiatric Surgery
 #Am. Board of Podiatric Orthopedics

Members:
 American Podiatric Medical Assn.
 Colorado Podiatric Medical Assn.

Fellows:
 Am. College of Foot & Ankle Surgeons
 #Am. Academy of Podiatric Sports Med.



Soothing, effective treatments for:

- Flat feet, high arches, heel pain, bunions & hammertoes
- Ankle sprains, fractures & chronic pain
- Nail problems
- Infant deformities
- Sports injuries & prevention
- Corns & calluses
- Diabetic foot care
- Nerve problems
- Skin problems
- Warts

Care that fits your schedule:

- Early morning, lunchtime & evening hours
- Same-day appointments
- Major insurances & credit cards accepted



2001 South Shields, Bldg. F
 Spring Creek Medical Park
 Fort Collins, CO 80526
 970-493-4660
 Fax 970-493-6710

3850 N. Grant Ave., Suite 130
 Loveland Medical Plaza
 Loveland, CO 80538
 970-667-0769
 Fax 970-493-6710

If originals, they are to be returned within 30 days of the above date _____

To the following Persons to Whom Information May Be Disclosed:

Name of person(s) or organization

Name of person(s) or organization

Address, City & State

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or the patient's personal representative.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient _____

Signature of Patient _____ *Date*

Signature of Patient Representative _____ *Date*

Relationship of Patient Representative to Patient _____