

**Premier Podiatry**  
Permission Form

I \_\_\_\_\_ give Dr. Scott O'Connor D.P.M.  
Patient's Name Doctor's Name

My permission to:

- |  | YES   | NO    |
|--|-------|-------|
| 1. Leave medical information on answering machine, voicemail, etc.   | _____ | _____ |
| 2. Leave medical information with family members listed below.       | _____ | _____ |
| 3. Release medical records to the following individuals listed below | _____ | _____ |

\_\_\_\_/\_\_\_\_/\_\_\_\_

- **Please list individual by name**
- **Anyone not listed will not be given access to your medical records or information**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

\_\_\_\_\_  
**Patient Name (please print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Authorized Representative (if applicable)**

\_\_\_\_\_  
**Signature**