CARLSBAD –ENCINITAS PODIATRY
RONALD E. LIEBERMAN, D.P.M., F.A.C.F.A.S.
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RELEASE OF INFORMATION

Patient's Name_____ Date of Birth _____

The HIPAA privacy rule gives individuals the right to request restrictions on use and disclosures of their PROTECTED HEALTH INFORMATION (PHI). The individual is also provided the right to request confidential communications or that communications of PHI is made by different means.

I authorize Carlsbad –Encinitas Podiatry, to contact me in the following manner:

Home Telephone (_____) _____
____Please leave a message with detailed information
____Do not leave information

Cell Phone (_____) _____
____Please leave a message with detailed information
____Do not leave information

Work Telephone (_____) _____
____Please leave a message with detailed information
____Do not leave information

You have my authorization to release detailed information, including results to:

My Spouse: _____

Family Member: _____

Primary Care Physician: _____

Other: _____

_____ _____
Signature of Patient, Guardian or P.O.A Print Name

_____ _____
Relationship to Patient Date