Dr. Keith Penera, DPM
PODIATRIC MEDICINE AND SURGERY

HIPAA

Permission to discuss personal health information with other individuals.
Instructions:

1. Write the name of all family members or other individuals who are involved in the patient's health care and have the patient or the patient's personal representative sign and date the form.

2. If the patient's personal representative is signing the form on behalf of the patient, the personal representative must also sign and date the acknowledgment that he or she has the legal authority to do so.

Individuals to whom Dr. Keith Penera, DPM may disclose my personal health information for coordination of care purposes.
I hereby grant Dr. Keith Penera, DPM, its subsidiaries, and associated organizations permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

Name	Date of birth	Relationship (friends, relatives, etc.)	Phone #

1. _____

2. _____

3. _____

4. _____

5. _____

I understand that if I do not list anyone and I am not present or am incapacitated, Dr. Keith Penera, DPM may share my information with family, friends or others that Dr. Keith Penera, DPM has determined, based on professional judgment, that is in my best interest and necessary for coordination of care and/or payment for health care services I have received from Dr. Keith Penera, DPM. This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

X _____ / YES OR NO

Signature of patient — Patient phone number / Can we leave detailed messages?

I understand that I have the ability to revoke identified representatives at any time by making modifications directly to the form and/or choosing to revoke all rights with all identified individuals be selecting option below.

☐ **Revoke all rights to discuss personal health information with all individuals mentioned above.** *TO REVOKE ONLY*

Signature of patient or legal representative _____ Date _____

Personal representative acknowledgment - *MINOR REPRESENTATIVE OR PATIENT REPRESENTATIVE ONLY*
If the patient is a minor or has a personal representative, I represent that I am the legal personal representative of the patient named above and I have the legal authority to act on behalf of the patient in making decisions related to health care.

Signature of patient or legal representative _____ Date _____

Print name of patient or legal representative _____