

JOEL D. FOSTER DPM, PC

I hereby give my consent for Dr. Joel D. Foster DPM, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPHO).

With this consent, Joel D. Foster DPM, PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPHO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, Joel D. Foster DPM, PC may mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements.

With this consent, Joel D. Foster DPM, PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPHO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Joel D. Foster DPM, PC use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Joel D. Foster DPM, PC may decline to provide treatment.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Patient's Name

Date
