Advanced Care Foot & Ankle

Dr. Craig A. Wilkes

Doctor of Podiatric Medicine

Patient Consent for Use and Disclosure of Protected Health Information

This form is necessitated by HIPAA (Healthcare Information Privacy and Accountability Act) Federal Privacy Regulation. I hereby give my consent for Dr. Craig A. Wilkes to use and disclose protected health information (PHI) about me to carry out treatment, obtain payment and perform healthcare operations.

With this consent, Dr. Craig A. Wilkes may call the phone number(s) provided by me and leave a message in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders and any call pertaining to my clinical care, including laboratory results. With this consent, Dr. Craig A. Wilkes, may mail to my home or alternate locations any items that assist the practice in carrying out healthcare operations, such appointment reminders and financial statements. With this consent, Dr. Craig A. Wilkes may use any pertinent patient data and patient photographs for clinical research and /or publications. In such case, patient identifying information will be removed to protect patient privacy.

By signing this agreement, I am consenting to allow Dr. Craig A. Wilkes and any healthcare associates involved in patient care or research, access to my patient records.

I have the right to request in writing that Dr. Craig A. Wilkes restrict how it uses my PHI to carry out healthcare operations. I may at any time revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior written consent.
( ) initials

Patient Consent for Examination/Treatment

I hereby give Dr. Craig A. Wilkes my consent to examination and to perform any and all procedures medically necessary for the diagnosis of my foot problems. It is agreed that Dr. Craig A. Wilkes, his staff and associates will provide all possible and practical care to the best of their skills and knowledge. I understand that it is my responsibility to fully comply with all physician orders and recommendations to obtain the best outcome possible. The doctor will discuss the likelihood of improvement of my medical condition. All efforts will be made to achieve positive outcome; however, I understand that despite treatment, there is a possibility my condition may not improve.
( ) initials

I have read and fully understand the contents of this form:

Please print full name _____

Signature of Patient/Guardian_____ Date_____