

**Allen Foot Doctors, partner of StrideCare
Neha W Singh, DPM, FACFAS and Sahil Handa, DPM
504 N Watters Rd, #160, Allen, TX 75013**

Patient Authorization To Use and Disclose Protected Health Information (PHI)

Patient Name: _____ DOB: _____

I hereby authorize the above named Practice (the "Practice") to use and disclose the following Protected Health Information ("PHI") (example: lab results, x-ray studies, information about your health condition and treatment) and may use it for the following: (ex. General knowledge or treatment).

The above described PHI may be released to the following entities (example: spouse, siblings, children, other physicians). Please list name and relation:

I understand and acknowledge that:

1. The office **will not** receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
2. This authorization is voluntary and I may refuse to agree to its terms without affecting and of my rights to receive health care at the Practice.
3. This authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention "Privacy Officer."
4. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
5. The information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.
6. My healthcare and payment for my health care will not be affected if I do not sign this form.
7. I may see and copy the information described in this form if I ask for it. And I can get a copy of this form, if I ask for it.
8. This form was completely filled in before I signed it, and I acknowledge that all of my questions were answered to my satisfaction, and that I fully understand this authorization form, and have received and executed this copy.
9. This authorization is valid as of the date I signed below and shall remain valid for a period of one year.

Name of Individual (printed)

Signature of Individual

Date