Dr. Joshua R. Modlin, D.P.M.
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CONSENT TO RELEASE
OF PATIENT INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTH CARE OPTIONS

Release of information: I hereby authorize Dr. Joshua R. Modlin, D.P.M. to disclose by telephone, electronic data interchange or by mail all of any part of my records for payment purposes, including but not limited to, any government agencies, insurance carriers, or others who are financially liable for my treatment and medical care including with limitation, hospital or medical services companies, insurance companies, workers' compensation carriers, welfare funds, or my employer, all information needed to substantiate payment for such treatment and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I understand and agree that mental health information, HIV/AIDS related information and/or substance abuse related information may be disclosed, in accordance with my prior written consent or the consent of my legal representative.

Dr. Joshua R. Modlin, D.P.M. may also disclose all of any part of my medical record for treatment purposes, including, but not limited to, any physician documented within the medical record or to partners of treating physicians, on-call or consultants utilized by any physician of record, to any health care facility that I am transferred to for continuance of care including the ambulance service which transfers me, and to the pharmacy of my choice where I purchase my prescriptions.

I also authorize Dr. Joshua R. Modlin, D.P.M. to use and disclose all or any part of my medical record for it's healthcare operations which include, but are not limited to, the management and administration of Dr. Joshua R. Modlin, D.P.M., Dr. Joshua R. Modlin, D.P.M. quality assurance and peer review activities, auditing, credentialing, and marketing.

Notice of Privacy Practices: I understand that I have the right to review Dr. Joshua R. Modlin, D.P.M. Notice of Privacy Practices prior to signing this consent. I acknowledge that I have been referred to, and have received a copy of Dr. Joshua R. Modlin, D.P.M. Notice of Privacy Practices which summarized the ways my medical record may be used or disclosed by Dr. Joshua R. Modlin, D.P.M. and states my rights with respect to my medical information. I understand that Dr. Joshua R. Modlin, D.P.M. has the right to revise its privacy practices and to amend the Notice. I have been informed that in the even Dr. Joshua R. Modlin, D.P.M. revises its privacy practices, a revised Notice will be posted in the office waiting room.

Right to Restrict Disclosures: I understand that I have the right to restrict how Dr. Joshua R. Modlin, D.P.M. uses and discloses all or any part of my medical record for treatment, payment, or health operations. I further understand that Dr. Joshua R. Modlin, D.P.M. does not have to agree to such restrictions.

Right to revoke at any time: I have the right to revoke this consent at any time. I understand that any revocation by me of this consent will only apply to future uses and discloses of my medical records and that such revocation is not effective as to previous uses and disclosures which occurred prior to the revocation. Such revocation shall be delivered to Dr. Joshua R. Modlin, D.P.M. in writing.

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Signature of Patient/Guardian/Legal Representative Date Signed