FOOT & ANKLE

Kimberlee Hobizal, DPM
Tresa Wize, DPM
Specializing in Reconstruction & Trauma

REQUESTED RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM (PHI)

I,_______________________________, give permission to Heritage Valley Medical Group Foot and Ankle to leave information on an answering machine. I understand this may pertain to medical information.

______________________________ ________________________
Signature Date

I also give permission for the following people to be given information:

	Name	Relationship
1.		
2.		
3.		
4.		

______________________________ ________________________
Signature Date

Right to revoke: You make revoke this authorization at any time except to the extent that we have relied on this authorization. To revoke this authorization, you must submit a written revocation to our Privacy Policy Officer.

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