RHODE ISLAND FOOT CARE, INC.

I hereby authorize Rhode Island Foot Care, Inc. to speak to the following people regarding my medical condition:

Name:	**Relationship:**
______________________________________	__________
______________________________________	__________
______________________________________	__________
______________________________________	__________

I understand I may revoke this authorization at any time by informing the physician's office in writing.

______________________________________	__________
Patient Name (print)	Date of Birth
______________________________________	__________
Patient Signature	Date
______________________________________	__________
Guardian Signature/Relationship	Telephone

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _________________________, have been provided a copy of Rhode Island Foot Care, Inc. notice of privacy practices.

____________________________	______________________
Signature of Patient	*Date*