

Ladine Podiatry

3221 S Memorial Drive, Suite C, New Castle, IN 47362

**ACKNOWLEDGEMENT OF RECEIPT FOR THE
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Patient Signature

Date

Parent or Authorized Representative (if applicable)

Date

**AUTHORIZATION TO SHARE PROTECTED
HEALTH INFORMATION**

I hereby authorize Ladine Podiatry to release information regarding myself contained in their records to the following people:

Name: _____

Name: _____

Name: _____

Name: _____