ATLANTIC FOOT SPECIALISTS P.L.L.C.
PRIVACY AGREEMENT

I (please check one) ( )DO ( )DO NOT authorize the Doctors and Staff of Atlantic Foot Specialists P.L.L.C. to leave messages and/or test results for me at home or on my answering machine. I agree to messages even if my identity is not given on my recorded message or designated number(s).

I (please check one) ( ) DO ( ) DO NOT allow messages to be left with my employer, such as changes in appointment time.

I authorize the Doctors and Staff of Atlantic Foot Specialists P.L.L.C. to discuss my medical records with my family members indicated below:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize Atlantic Foot Specialists P.L.L.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that this authorization will remain in effect for as long as my dependent or I remain a patient.

I agree to the above statements and consider it to be valid from the date signed. I agree to notify Atlantic Foot Specialists P.L.L.C. in writing if I wish to these agreements to be cancelled.

_____ _____

Signature Date

_____

Print Name