

# NEWTOWN PODIATRY ASSOCIATES, P.C.

## PODIATRIC MEDICINE AND SURGERY

William S. Lynde, D.P.M., F.A.C.F.A.S.  
Diplomate - American Board of Podiatric Surgery  
Board Certified in Foot and Ankle Surgery  
Fellow - American College of Foot Surgeons

Paul E. Sullivan, D.P.M., F.A.C.F.A.S.  
Diplomate - American Board of Podiatric Surgery  
Board Certified in Foot Surgery  
Fellow - American College of Foot Surgeons

Teresa M. Propato, D.P.M., A.A.C.F.S.  
Associate - American College of Foot Surgeons

### HIPAA CONSENT TO RELEASE OF MEDICAL RECORDS

In order to facilitate the continuity of my medical care and treatment, I consent and authorize my physicians and authorized agents and employees of Newtown Podiatry Associates, and other hospitals, practices, clients, and providers affiliated with Newtown Podiatry Associates to use/or disclose my personal health information and to release medical records relating to my inpatient or outpatient care in their control and possession, including but not limited to progress notes, discharge summary, operative notes, results of lab tests, radiology reports and consultations and other information about my Medical Records, to other Systems Providers and to the Department of Public Welfare and/or its assigned agencies (if I am receiving services and payment under the Medical Assistance Program), my insurance company, family physician, other providers of following care, family members or friends involved in my medical care and to any other person or entity identified below.

Others \_\_\_\_\_ Address: \_\_\_\_\_

I understand that the information from my Medical Record may be used and/or disclosed by Newtown Podiatry Associates to request authorization, bill or obtain payment for my care and treatment from insurance companies, managed care companies, government programs, or other responsible parties and their agents or auditors, and I consent to the use and disclosure of my medical information for such purposes. I understand that information from Medical record may be used for educational, administrative or approved purposes.

I understand that the release of information about my treatment for drug abuse, alcohol abuse or mental illness, and HIV or AIDS information will require me to sign a separate consent form. The law permits certain disclosures of medical records and information to those responsible for [paying for your medical care and to those providing current and follow-up medical care.

I release my physicians, and their employees, agents, and representatives from legal responsibility or liability for the disclosure of my Medical Records and the information contained therein. Once my Medical Record is disclosed, it may no longer be protected by federal and/or state privacy laws.

I give this consent voluntarily and with full understanding of its nature.

I acknowledge that I have received the Newtown Podiatry Associates Privacy Practice, which explains the greater detail the uses and/or disclosures of my personal health information described above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_