



**Family Podiatry
Group of
Tampa, P.A.**

Podiatric Physicians and Surgeons

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Diplomate American Board
of Podiatric Orthopedics
and Primary Podiatric Medicine

Diplomate American Board of
Podiatric Surgery

Fellow American Academy
of Podiatric Sports Medicine

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read them and understand the Notice of Privacy.

Patient Name: _____

Parent/Guardian/Legal Representative: _____

Signature: _____

Today's Date: _____

Authorization to Share Private Health Care Information

I authorize the physicians and staff to share my protected health care information with the following persons without any additional consent requirements:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Parent/Guardian/Legal Representative: _____

Signature: _____ Date: _____

Witness: _____