FREDRICK S. WILSON, D.P.M.
39180 FARWELL DR., SUITE 110, FREMONT, CA. 94538
TEL. NO. (510) 796-2191

ACKNOWLEDGMENT 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 had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

IN THE EVENT OF BEING INCAPACITATED, I AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO RECEIVE MY MEDICAL RECORDS:

NAME & RELATIONSHIP PHONE # (IF DIFFERENT)

_____ _____

_____ _____

It is the responsibility of this office to inform our patients when medical records have been requested by fax transmission. By signing this consent form you are giving Dr. Fredrick Wilson, D.P.M. and his staff, permission to fax your medical information to the individuals or facilities listed below for billing purposes or to help further your treatment.

- Patient or patient's authorized representative
- Physicians requesting information pertaining to patient's medical needs
- Patient's insurance company
- Prosthetic labs (i.e. orthotics or DME)
- Hospitals or Outpatient centers
- Pharmacies
- Imaging centers for x-rays, nuclear medicine, MRIs, NIVS, etc.
- Physical Therapy facilities
- Home healthcare providers
- Unilab / Quest Diagnostics

_____ _____

Signature Date