



New Jersey Foot and Ankle Specialists, LLC

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**Specializing in Wound
Healing, Limb
Preservation and
Reconstructive Surgery of
the Foot and Ankle**

Permission To Treat

By signing below, I acknowledge that:

- The doctor, associate doctor and staff of the medical practice noted on this form and hereafter referred to as DOCTOR, are authorized to treat the patient named on this form
- DOCTOR is authorized to collect, use and exchange Individually Identifiable Health Information consisting of the patient's past, present and future medical information and personal information to treat patient, communicate with patients' other health care providers, seek payment, carry out necessary business functions, and mandated government reporting requirements. These situations and others, as well as your rights regarding this information are explained in our separate Notice of Privacy Practices provided for you.
- I have received a copy and have acknowledged both the HIPPA and financial compliance policies for this office.

Signature: _____

Printed Name: _____

Date: _____

*If patient is under 18 years of age or unable to consent on their own behalf for whatever reason, please sign below

X _____
(Signature of parent, guardian or power of attorney)

Printed Name: _____