

**Judson L. Siegel, DPM**  
**Podiatric Medicine and Surgery**  
**7 Wilkins Drive**  
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**Appointment reminders and Health Care Information Authorization**

Dr. Judson Siegel and members of the staff may need to use your name address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone, and you are not at home, a message will be left by voice mail or answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time: however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to obtain authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time. (165 524)

This notice is effective as of April 14, 2003. This authorization will expire seven years after the date on which you last received services from Dr. Siegel.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Parent if Minor

\_\_\_\_\_  
Authorized Provider Representative