FEET FIRST FOOT CARE SPECIALISTS, LLC
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Diplomat American Board of Foot and Ankle: Certified in Foot Surgery

Consent Form
For the Use and Disclosure of Health Information

Name of Patient: _____
Social Security Number: _____
Date of Birth: _____

By signing this Consent Form, I understand that:

1. I am giving my consent to Adam Mucinskas, DPM (the ñPracticeò) for use and disclosure of the patientôs identifiable health information for the following purposes and activities:

   Treatment (including, but not limited to disclosures necessary for the consultations with and /or referrals to other providers, the coordination of the provision of care, and the scheduling of care).

   Payment (including, but not limited to, disclosures necessary for obtaining payment for the provisions of care, determining eligibility for coverage, billing and utilization review).

   Health Care Operations (including, but not limited to, disclosures necessary for conducting quality assessment and improvement programs, care coordination, evaluating provider performance, conducting provider training programs, all of which might be conducted by the Practice or by organizations that license, accredit, monitor or contract with the Practice as a network provider, and business management and administrative activities of the Practice).

2. The information disclosed may include information relating to the patientôs:

   - Human immunodeficiency virus (ñHIVò) infection or acquired immunodeficiency syndrome (ñAIDSò)
   - Treatment for or history of drug or alcohol abuse
   - Mental or behavioral health or psychiatric care

3. This consent will remain valid until it is revoked by me or my duly authorized representative.

Signature of patient or patientôs representative: _____
Date: _____
Printed name of patientôs representative: _____
Relationship to patient giving representative authority to act for patient: _____