

BRIAN J. FRENCH D.P.M., F.A.C.F.A.S.

DIPLOMATE AMERICAN BOARD OF PODIATRIC SURGERY
FELLOW AMERICAN COLLEGE OF FOOT AND ANKLE SURGEONS
8620 SOUTH PULASKI
CHICAGO, ILLINOIS 60652
TELEPHONE: (773) 585-8200
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RELEASE OF MEDICAL INFORMATION

I _____ AUTHORIZE THE RELEASE OF ANY MEDICAL
INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT.

SIGNED _____ DATE _____

PATIENT RESPONSIBILITY

FILING INSURANCE CLAIMS IS A SERVICE WE PROVIDE WITHOUT CHARGE AND IN NO WAY RELIEVES YOU
OF RESPONSIBILITY FOR YOUR BILL. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT NOT
PAID BY THE INSURANCE COMPANY.

SIGNED _____ DATE _____

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 UNDERSTOOD THE NOTICE.

SIGNED _____ DATE _____

CONSENT FOR TREATMENT

I HEREBY GIVE PERMISSION TO **BRIAN J. FRENCH, D.P.M.** TO ADMINISTER TREATMENT AND TO
PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS
AND/OR TREATMENT OF MY FOOT CONDITION.

SIGNED _____ DATE _____

WITNESS _____ DATE _____