DR. ARASH ARABI
1325 McFarland Blvd. Ste 209
Northport, Alabama 35476
Phone # (205) 464-9619
Fax#(205) 464-9646

PRIVACY POLICY/CONSENT AND MEDICAL RELEASE

I,___________________________________have been informed of Black Warrior Foot & Wound Center's Notice of Privacy Policies and understand that my protected health information may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the Privacy Policy. I also hereby authorize the release of any medical records or x-rays to my insurance company, and/or referring physician. I also hereby authorize payment of my insurance carrier directly to BWFWC for any charges incurred for medical treatment at said facility in which care is rendered.

CONSENT TO TREAT: I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Dr.Arabi and staff. This includes but is not limited to: Initial or Follow-up evaluations, examinations, x-rays, laboratory procedures, other tests, medications, medical treatment, surgery, home instructions, orthotics, other durable medical equipment, photographing and/or videotaping and/or other services rendered to the patient by Dr.Arabi. The undersign agrees that it is their responsibility to contact and/or schedule with BWFWC for any follow up visits, other services, prescriptions and items ordered for the patient. I am aware that the practice of medicine and surgery is not an exact science. Furthermore, I understand that the provider exercises their care with reasonable skill and diligence, but no guarantee has been or can be made as to the results of the treatments or examinations.

By signing below, I certify that I have read the above statement and agree.

____

Patient or Guardian Signature **Date**

**** In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures on their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.**

I authorize BWFWC and its staff to talk to and release information to the following individuals regarding my healthcare. I authorize the release of my private medical information to the following persons:

___________________________________**relationship to patient** ______________________

___________________________________**relationship to patient** ______________________

Patient Signature________________________________**Date** _________________________