



# Dr. Keith J. Kalish

**Board Certified Medical & Surgical Foot Specialist • Podiatrist**

Diplomate American Board of Podiatric Surgery

Diplomate American Board of Podiatric Orthopedics

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

- I give permission for Dr. Kalish to use the address given on the patient information sheet for written communications.
- I give permission for Dr. Kalish to use the phone number(s) given on the patient information sheet for oral communications.
- I give permission for Dr. Kalish to use the email address given on the patient information sheet for written communication.

\_\_\_\_\_  
Patient Name (please print)

Please release my medical information to: (i.e. family member, friend, etc)

\_\_\_\_\_  
relationship: \_\_\_\_\_

\_\_\_\_\_  
relationship: \_\_\_\_\_

**X**  
\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

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