Foot Specialist Associates P.C.

Consent to use of PHI

Protected Health Information

Our notice of privacy practice provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice of privacy practices before you sign this consent. As provided in our notice, the terms of our notice, the terms of our notice may change if we change our notice, we will furnish you with a revised copy at your request.

You have the right to request that we restrict how protected health information about you is used for disclosed for treatment, payment, or health care operations. We are not required to agree to your requested restrictions. However, if we do agree, then we are bound by our agreement.

By signing this form, you consent to our use and disclosure of your PHI about you for treatment, payment, and heath care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

POLICY: PATIENT PRIVACY RIGHTS

Provider will implement policies and procedures relating to patient privacy rights as required by the privacy rule of the administrative simplification provision of the health insurance portability and accountability act of 1996.

PROCEDURE

-Patients cared for by the provider have the following privacy rights:
-to receive a copy of the provider's notice of privacy practices
-to request restrictions on the uses and disclosures of health information
-to request to receive confidential communication
-to access their protected health information for inspection and/or copying
-to amend their health care information
-to request an accounting of disclosure of health information

-Individuals have the right to complain if they believe the provider has committed any privacy violations.

-The privacy policies of the provider detail the requirements for each of these rights and provide procedures for implementation.

-Staff of the provider are provided with annual training regarding patient right with regards to their health information.

PLEASE READ AND SIGN: I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF BENEFITS TO FOOT SPECIALIST ASSOC., P.C. OR TO THEIR DOCTORS. I ASSUME RESPONSIBILITY FOR PAYMENT OF ANY BALANCE NOT COVERED BY MY INSURANCE

Patient Signature: _____ Date: ____/____/_____