PATIENT CONSENT (HIPAA) FORM

Date: _____

I understand that under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*, I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing how you may restrict my private information. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the content that you have taken action relying on this consent.

Print Patient Name:_____

Signature:_____

If you're a guardian of ,OR patient is a minor – Your Relationship to Patient _____

Please list the names and relationship of those whom you'd <u>give us permission to leave a phone message</u> with OR <u>someone who might call on your behalf</u> regarding your patient account information and/ or podiatry (foot) care.

1.)_____Phone # _____ Relationship _____

2.)_____Phone # _____ Relationship _____

3.)_____Phone # _____ Relationship _____