Elite Foot & Ankle Center

HIPAA PATIENT CONSENT FORM

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THE NOTICE CONTAINS A PATIENT RIGHTS SECTION DESCRIBING YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO THIS RESTRICTION, BUT IF WE DO, WE SHALL HONOR THAT AGREEMENT.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING SIGNED BY YOU, AT ANY TIME. HOWEVER, SUCH REVOCATION SHALL NOT AFFECT ANY DISCLOSURES THAT WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR CONSENT. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS
- THE PRACTICE HAS A NOTICE OF PRIVACY PRACTICES AND THAT THE PATIENT HAS THE OPPORTUNITY TO REVIEW THIS NOTICE
- THE PRACTICE RESERVES THE RIGHT TO CHANGE THE NOTICE OF PRIVACY PRACTICES
- THE PATIENT HAS THE RIGHT TO RESTRICT THE USE OF THEIR INFORMATION BUT THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS
- THE PATIENT MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME AND ALL FUTURE DISCLOSURES WILL THEN CEASE
- THE PRACTICE MAY CONDITION RECEIPT OF TREATMENT UPON THE EXECUTION OF THIS CONSENT

BY SIGNING BELOW I REPRESENT AND WARRANT THAT I HAVE AUTHORITY TO SIGN THIS DOCUMENT AND UNDERSTAND THE INFORMATION CONTAINED IN THIS NOTICE INCLUDING, BUT NOT LIMITED TO, HOW THE PRACTICE MAY USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION AND MY RIGHT ASSOCIATED WITH MY PROTECTED HEALTH INFORMATION.

_____ _____/_____/_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN/HEALTHCARE POWER OF ATTORNEY *DATE*