Notice of Privacy Practices

This notice describes how medical information of yours may be used and/or disclosed, and how you can get access to this information.

Our Privacy Obligations: We are required by law to maintain the privacy of our protected health information (PHI) to provide with presentation of this document of our legal duties and privacy practices with respect to you and your PHI. When we use or disclose your PHI, we are required to abide by the terms of this notice or other notices in effect at the time of the use of disclosure.

Uses and Disclosures of Health Information: We can use and disclose PHI for purposes of treatment, obtaining payment, and other healthcare options without your authorization.

Treatment: To diagnose and treat your injury or illness. We may also disclose PHI to other providers such as hospitals, or other physicians treating you for continuity of care.

Obtaining Payment: To verify coverage or submit claims to a health insurer, or another company that arranges or pays the cost of some and/or all your healthcare services.

Healthcare Operations: For administration, planning, and various activities that improve the quality of the treatment you receive. Some examples are: confirmation calls, training programs, accreditation, licensing, credentialing and certification.

Individuals Involved in Your Care, Family and Friends: We may discuss PHI to a Family member and/or friend to help you in your care, for payment purposes when you are present or otherwise available prior to the disclosure. We may require a written consent from you due to your incapacity or emergency circumstances we may exercise professional judgement to determine whether a disclosure is in your best interest.

Abuse or Neglect: We may disclose PHI to authorities such as social workers/services that are authorized by law to receive reports of such abuse or neglect.

As Required By Law: We may use and disclose you PHI when required by law.

I (full name) _____ do hereby authorize Board Certified Foot Care & their Associates to release my PHI, including copies of my medical records, reports, or lab reports.

I understand that I have the right to revoke this authorization at any time. If I do revoke this authorization I must do so in writing. I understand that the revocatio will not apply to my insurance company when the law provides my insurer with the right to contest claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations. I understand th the information in my health records may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may contain information about behavioral or mental health services, and or treatment for substance abuse disorders.

I understand that authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Name: _____ Date: _____

Signature of Witness: _____ Date:_____