

PRIVACY CONSENT

(For the use and disclosure of protected health information)

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Delaware Podiatry Center, LLC to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize Delaware Podiatry Center, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and sale or dispensing of drugs, devices, equipment or other items required in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. I also understand that per Ohio law, if I accompany a minor to an office visit, I am responsible for co-payments and any deductibles at that the time of service, regardless of other arrangements made with the child's other parent. I understand that if I am age 18 or over, that I am responsible for my own bill, regardless of insurance coverage, unless I have a designated legal guardian who handles my financial affairs.

Consent related to the privacy notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Practice Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it agrees to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign the consent. I may revoke this consent at any time, but the practice may refuse further services at that time. This consent will remain in effect until I provide written notice of any changes. If I revoke this consent, the revocation does not take effect until the practice receives it.

*May we leave a message at your home with other residents? Yes or No

*On your answering machine/ voice mail? Yes or No

*Who may we talk to about your medical concerns on your behalf? _____

Relationship _____ Phone #: _____

Print Name: _____ Date: _____

Parent/Guardian: _____

Signature: _____