

Caring Podiatry

Where your feet come first

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as a part of my treatment, this facility originates and maintains health records describing my health history, symptoms, examination and the test results, diagnoses, treatment, and any plans for future care treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among any other healthcare professional who might contribute to my care, for example via facsimile, telephone, ect.
- A source of information for applying my diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed are accurate and actual.
- And as a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare officials.

I understand this practice will take great care to insure that any and all information pertaining to me and my treatment here will be handled with and emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required to agree to these restrictions. I understand that I may revoke this consent in writing, at any time, but not to the extent that the organization has already acted in.

I request the following restrictions to the use or disclosure of my health information:

Name of Patient: _____

Signature of Patient (or Legal Guardian): _____

Date: _____