BRANDYWINE FAMILY FOOT CARE / FOOT & ANKLE ASSOCIATES

PATIENT DISCLOSURE AUTHORIZATION (HIPAA)

With your permission, we can provide information to you in a variety of ways. Please indicate agreement with the following list by *checking ALL* that apply.

_____

PRINTED NAME of Patient

_____ _____

SIGNATURE of Patient, Parent (if under 18), Guardian or Personal Representative DATE

RELATIONSHIP TO PATIENT (*Circle One*) : Self Parent Guardian Personal Representative

Primary Phone Number: _____ Cell Home Work

Secondary Phone Number: _____ Cell Home Work

___ It is acceptable for you to leave information on my voicemail / answering machine, including appointment reminders at my PRIMARY phone number.

___ It is acceptable for you to leave information on my voicemail / answering machine, including appointment reminders at my SECONDARY phone number.

___ I do NOT want you to speak with any family members or friends regarding my condition.

___ It is acceptable for you to speak with ONLY the following family members / friends regarding my condition (please check all that apply) at either my PRIMARY or my SECONDARY phone number.

___ Spouse / Partner (please indicate name): _____

___ Sibling (please indicate name): _____

___ Children (please indicate name/names): _____

___ Friend (please indicate name): _____

___ Caregiver (please indicate name): _____

___ Other (please indicate name): _____

Please list any additional persons on the back of this form.

It is the patient's responsibility to notify the office staff of any changes to this Authorization.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes **Brandywine Family Foot Care / Foot & Ankle Associates** to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. Brandywine Family Foot Care / Foot & Ankle Associates, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review your current notice prior to signing this acknowledgement.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Office.

How to contact our Privacy Officer

Mail: Brandywine Family Foot Care
Attn: Privacy Officer
213 Reeceville Rd., Suite 13
Coatesville, PA 19320
Phone: 610-383-5220
Fax: 610-383-0390

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Brandywine Family Foot Care / Foot & Ankle Associates. Brandywine Family Foot Care / Foot & Ankle Associates is authorized to use and disclose health information about _____(PRINTED patient name) for treatment, payment and healthcare operation purposes consistent with its Notice of Privacy Practices.

_____

PRINTED NAME of Patient, Parent (if under 18), Guardian or Personal Representative

RELATIONSHIP TO PATIENT (*Circle One*) : Self Parent Guardian Personal Representative

_____ _____

SIGNATURE of Patient, Parent (if under 18), Guardian or Personal Representative DATE