Lee K. Gold, D.P.M., F.A.C.F.A.S.
Ignazio D. Perna, D.P.M., F.A.C.F.A.S.

HIPAA PATIENT SUMMARY OF PRIVACY PRACTICES

Uses and Disclosures of Health Information- We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by is or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization- Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosure Not Requiring Your Authorization- In the following circumstances, we may disclose your health information without your written instructions:

- To family members or close family members who are involved in you health care;
- For certain limited research purposed;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations, and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report products defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas, and as otherwise required by the law.

Patient Rights- As our patients , you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please contact us.

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy and that I have read (or have had the opportunity to read if I chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____ _____

Signature Date