Acknowledgement of Privacy Practice

Center For Foot & Ankle Care has provided me with the opportunity to review the Practice's Privacy Notice prior to my signing this consent. The privacy Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI) necessary for the practice to provide treatment, obtain payment and carry out its health care operations. A copy of the Privacy Notice is available to me now and in the future upon my request.

Center For Foot & Ankle Care reserves the right to change its privacy practices in accordance to applicable Federal and State laws.

I understand and consent to the following appointment reminders that may be used by Center For Foot & Ankle Care:

- A telephone call to the telephone number (s) provided by me whether it is home or business. A message may be left on an answering machine or with the person answering the given number. The person calling will give the name of the practice of Dr.'s name, time and date of the appointment.

I understand Center For Foot & Ankle Care uses a sign in sheet for patients. It may be seen by others seeking treatment on the same day. There is no PHI required on the sign in sheet. We make every attempt to black out patient's names upon signing in.

I understand that I have the right to request the practice restrict how my PHI is used and disclosed to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to any restrictions that I have requested. If the practice does agree to a requested restriction, then the restriction is binding on the practice.

I understand there are instances where no consent is required for Center For Foot & Ankle Care to disclose my PHI. Those are in accordance with Federal and State regulations and are listed in the Privacy Notice.

I further understand that I have the right to revoke this consent, in writing, any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance to this consent.

I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.

I understand that if I refuse to sign this consent evidencing my consent to the uses and disclosures described to me above and pertaining to the Privacy Notice, then the practice will **NOT** treat me.

I understand that I have the right to complain to the practice's Privacy officer if I feel my rights have been violated. All complaints **must be in writing.**

I have read and understand the foregoing notices and have had all my questions answered.

_____ _____

Name of Patient – Please Print Signature of Patient

_____ _____

Signature of Legal Representative, (legal guardian, parent, etc.) Relationship

_____

Date signed

For Office Use Only

Individual refused to sign.

Communications barriers prohibited obtaining the acknowledgement.

An emergency situation prevented us from obtaining acknowledgement.

Other – Please Specify

_____

_____