Save Your Sole Foot & Ankle Specialists

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PRIVACY PRACTICES

Our clinic is committed to protecting the confidentiality of information about you, and is required by law to do so. This notice describes how we may disclose your information to others.

Treatment: Our clinic may use the information about you to provide you with services and supplies. We may also share information with others that need information to treat you such as: surgery centers, other specialist's, testing centers, or other medical facilities that you are sent for treatment or to obtain supplies. This includes information provided to your insurance company from our office for any treatment or testing that your physician may order.

Payment: Our clinic may use and disclose information about you to get paid for medical services and supplies that we have provided to you. Your health insurance company may request to see parts of your medical record before they will pay us for treatment and supplies.

Legal: There are other circumstances when our clinic may have to give out your information such as court requests, workers compensation, and state and federal required government reporting.

Third Party: If you request your records be released to a third party such as your spouse, friend or relative, we will need a written release on file that authorizes us to do so.

WHAT ARE YOUR RIGHTS

You have the right to request:

- A copy of your health record. (There may be a charge for this).
- We communicate with you in a confidential way.
- We add or amend information about you that you believe is incorrect or incomplete.
- A paper copy of this information.
- An accounting of disclosures.

OUR COMMITMENT TO RESPECT YOUR PRIVACY

Our clinic is committed to respecting your privacy. We are dedicated to keep your health information private and only share it with those parties that need it for treatment of your health condition. At any time that you feel that you would like more information on our clinic's privacy practices or you have a concern, please let your provider know so that we may take actions to rectify the situation. We truly value our patients and are committed to helping them achieve the best outcome.

I, ______________________________ hereby consent to the use, access, and disclosure of my protected health information to:

Name: ____ Relationship: ______________________________________

Name: ____ Relationship: ______________________________________

Name: ____ Relationship: ______________________________________

____ No one.

I acknowledge that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Signature:__________________________________ Date:_____________________________