FootCare, P.A.
Consent for Use and Disclosure of Health Information

I understand that as part of the provision of healthcare services, **FootCare, PA.** Creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that **FootCare, P.A.** reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notices to the address I have provided. 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 the office is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information that is used or disclosed for the purposes of treatment, payment, or health care operations be restricted. **FootCare, P.A.** is not bound by the restriction unless it is in agreement with the restriction.

_______________________________ Patient's Name Printed

_______________ Date

_______________________________ Patient's Signature (Or Guardian, If a Minor)

_______________ Date of Birth (For Identification Purposes Only)