FREMONT PODIATRIST GROUP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO THE USE AND DISCLOSURE, OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

Patient Name: (Print) _____Date of Birth_____:
By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Fremont Podiatrist Group I understand that as part of my healthcare, Fremont Podiatrist Group originates and maintains health records describing my health history, symptoms, examination and tests results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were accurately provided.
A tool for routine healthcare operations - such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
:
To object to the use of my heath information for directory purposes.
To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Fremont Podiatrist Group is not required to agree to the restrictions requested. To revoke this consent in writing, except to the extent that Fremont Podiatrist Group has already taken action 'in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

PATIENT
I authorize Fremont Podiatrist Group to use my Protected Health Information as described in the Notice of Privacy Practices.

X_____
Signature of Patient or Legal Representative Date Witness

For Internal Use Only
Accepted____
Declined____ _____ _____
Staff Signature Title Date