## Privacy Practice & HIPAA Release Information

Tallahassee Podiatry Associates (TPA) 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 disclosures of my protected health information (PHI) that is necessary for this practice to provide medical treatment, obtain payment, and carry out its health care operations. A copy of this privacy notice is available to me now and in the future upon my request.

TPA 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 which may be used by TPA: a telephone call to the telephone number(s) provided by me whether it is home, work, or mobile. A message may be left on an answering machine, with a person answering the given number, or text message to the mobile number provided. The person calling will give the name of the practice or doctor's name, time, and date of the appointment.

I understand TPA uses a fax/efax machine to transmit certain information pertinent to my care to HIPAA compliant entities, such as a doctor's office, insurance company, etc. If I request a fax be sent to a personal or business fax, I will sign a release.

I understand anyone picking up any information for me must have photo identification and authorization.

I understand TPA uses a sign in sheets for patients. It may be seen by others seeking treatment on the same day. There is no PHI required on the sign in sheet.

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

I understand there are instances where no consent is required for TPA to disclose my PHI. Those are in accordance with federal and state regulations and are listed in the privacy notice.

This consent is valid for seven (7) years. I further understand I have the right to revoke this consent, in writing, any time for all future transactions, with the understanding any such revocation shall not apply to the extent TPA has already taken action in reliance to consent.

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

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

I understand I have the right to complain to TPA's administrator if I feel my rights have been violated. All complaints must be in writing.

I have read and fully understand the forgoing notice and have had all my questions answered.

Initial:_____ Date:_____

**Privacy regulations require our practice to have a signed release which allows family members and/or friends regarding your medical treatment(s) and financial information. Each person you wish to grant contact must be listed individually by name (Including spouse or significant other).**

**Please print name, relationship, and telephone number for each person you are authorizing release of your PHI and/or financial information. This authorization will remain in effect until at such time changes are made in writing by the patient or authorized legal representative.**

| Name | Relationship | Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |