

# SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding  
The attached Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

**Uses and Disclosures of Health Information.** We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

**Uses and Disclosures Based on your Authorization.** Accept as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures Not Requiring Your Authorization.** In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidence;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

**Patient Rights.** As our patient, you have the following rights;

- To have access to and / or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.



**Advanced Foot Care Center of Rochester**  
**Joseph G. DiPrima, D.P.M., F.A.C.F.A.S.**

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585-249-0020

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2828 Baird Road, Suite B  
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585-249-0020

**ACKNOWLEDGMENT OF RECEIPT  
OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been given the opportunity to read a copy of Notice of Privacy Practices. I acknowledge that I have read and understood the notice and that I may receive a written copy if I so choose.

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Patient Name (please print)

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Date

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Parent or Authorized Representative (If applicable)

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Signature