

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.

Rochester Office
1561 Long Pond Road, Suite 210
Rochester, NY 14626
585-249-0020

Fairport Office
2828 Baird Road, Suite B
Fairport, New York 14450
585-249-0020

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Advanced Foot Care Center of Rochester to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Advanced Foot Care Center of Rochester describes such uses and disclosure more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Foot Care Center of Rochester reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Joseph G. DiPrima, D.P.M
2828 Baird Road, Suite B, Fairport, New York 14450.

With this consent Advanced Foot Care Center of Rochester may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results among others.

With the consent, Advanced Foot Care Center of Rochester may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With the consent, Advanced Foot Care Center of Rochester may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advanced Foot Care Center of Rochester restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow advanced Foot care Center of Rochester to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing accept to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Foot care Center of Rochester may decline to provide treatment to me.

Signed By _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patients Name Print Name of Legal Guardian, if applicable

Parent/Guardian must be provided with a signed copy of this authorization form.

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**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.

Patient Name (please print)

Date

Parent or Authorized Representative (If applicable)

Signature