AMERICAN FOOT & ANKLE CLINIC OF TAMPA BAY

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Dr. Donate originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans or 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 health professionals who contribute to my care, such as referrals. A

source of information for applying my diagnosis and treatment information to my bill.

A means by which a third---party payer can verify that services billed were actually provided.

A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "*Notice of Patient Privacy Practices*", that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: I

have the right to review the "*Notice*" prior to acknowledging this consent.

I have the right to restrict or revoke the use or disclosure of my health information for other uses or purposes.

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.

Restrictions:

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

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Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation, also please be sure to include their phone number(s) so we may contact them in the event that it may be necessary. Example: spouse (name), children (names), other relatives (names), friends or caregivers (names). ________________________________

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5322 Primrose Lake Circle, Suite F, Tampa, FL 33647
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Messages or Appointment Reminders:

May we leave a message at your home using doctor's/practice name: Yes___No____

May we leave a message at your work using doctor's/practice name: Yes___No____

Do not leave a message: _______

Messages will be of a non---sensitive nature, such as appointment reminders, upcoming events, etc.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept/decline** (please circle one) the information of this consent.

____ ____

Patient/Guardian Signature **Print Name of Person Signing**

____

Date

*If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for treatment, payment or healthcare operations? Yes______No____

FOR OFFICE USE ONLY:

_______"Consent Form" received and reviewed by____on __________________

_______"Consent Form" signature refused by patient ______________Restrictions added by Patient

_______"Consent Form added to patient's medical record on __________________

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