Ankle and Foot Center
977 Broad Street
Bloomfield, NJ 07003
Phone: (973) 338-1111

Authorization for Use or Disclosure of Protected Health Information

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications

I give my permission for this office (Ankle and Foot Center) to leave messages on my home and/or cell phone voicemail. ***(Circle One - Home / Cell)***

_____	_____	_____
Print Patient's Name	**Patient's Signature**	**Date**

I make the following special request of confidential communications: The people whom, in addition to myself, may be given this confidential information are:

Name	**Relationship to Patient**	**Telephone**
_____	_____	_____
_____	_____	_____

I acknowledge that I have received and or been granted access to your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____	_____	_____
Print Patient's Name	**Patient's Signature**	**Date**