

ANKLE & FOOT CLINIC OF EVERETT

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. Except 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 incidents;
- 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.

If you have a question, concern or complaint regarding our privacy practices, please refer to the attached Notice of Privacy Practices for the person or persons whom you may contact.

ANKLE & FOOT CLINIC OF EVERETT

3131 Nassau Street, Suite 101 * Everett WA 98201

Phone (425) 339-8888 Fax (425) 258-6933

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice. (Rev:8/26/05)

Patient Name (please print)

Date

Patient Signature

Parent or Authorized Representative (if applicable)
(please print)

Parent or Authorized Representative Signature

Ankle & Foot Clinic of Everett
3131 Nassau Street, Suite 101 * Everett Wa. 98201
Phone (425) 339-8888 Fax (425) 258-6933

Consent for Leaving Messages
Consent to Leave Messages /Share Information with Family/Friends

I understand that my healthcare information at the Ankle & Foot Clinic of Everett is protected and I have received a copy of their Notice of Privacy Practices.

In order for the Ankle & Foot Clinic of Everett to leave detailed messages on my voice mail or answering machine, I need to give permission to the Ankle & Foot Clinic of Everett.

Consent for Leaving Messages (please check box)

Yes No

I consent to information regarding myself (or my child's / under the age of 18) lab tests results or detailed appointment reminders/instructions be left on my voice mail or answering machine.

Consent for Shared Information with Family and Friends (please check box)

Yes No

I wish family members or friends to have access to my health care information. The name(s) listed below are family members or friends to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

(Print) _____

Patient Name

Date of Birth

Patient/Parent Signature

Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect. (Rev:12/31/05)