SUMMARY OF 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.

Uses and Disclosures of Health Information

We will use and disclose our 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 healthcare 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 discuss your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

- For certain limited research purpose.
- For purposes of public health and safety.
- To Government Agencies for purposes of their audits, investigations, and other oversight activities.
- 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 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 our of privacy practices.

If you have any questions, concerns or complaints regarding our privacy practices, please refer to the Notice of Privacy Practices in each office waiting room.

Acknowledgement of Receipt of Privacy Practices

_____	_____	X _____
Patient Name	Date	Signature

ESSEX UNION PODIATRY

AUTHORIZATION
FOR RELEASE OF MEDICAL RECORDS

HIPAA regulations do not allow for the release of medical information without your expressed authorization. Please list below any individual you authorize to receive medical information on your behalf.

_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship
_____	_____
Print Name	Relationship

By signing below, I authorize the individuals listed above to receive medical information on my behalf in accordance with HIPAA regulations.

_____	_____	X _____
Patient Name	Date	Patient/Guardian Signature

☐ **I acknowledge that I have chosen not to authorize any individual to receive medical information on my behalf by initialing below.**

_____

Initial