

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

**PHILIP RADOVIC, D.P.M., F.A.C.F.A.S.**  
*Podiatric Medicine & Surgery*

DIPLOMATE, AMERICAN BOARD OF PODIATRIC SURGERY  
DIPLOMATE, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS &  
PODIATRIC MEDICINE

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**NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT**

*This notice describes how patient protected health information may be used and disclosed and the patient's right to access to this information. Please review carefully.*

The *Health Insurance Portability & Accountability Act of 1996* ("HIPAA") requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed. Any misuse personal health information is subject to penalties.

- We may use and disclose patient medical records only for the following purposes:
  - Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
  - Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
  - Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
- We may create and distribute non-identified health information by removing all references to individually identifiable information.
- We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
- Any other uses and disclosures may be made only with patients written authorization. Patient may revoke such authorization in writing, except to the extent that we have already taken actions relying on patient authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.
- Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Privacy Officer:**
  - The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient. We are not required to agree to a requested restriction. However, if we do, we must abide by it unless patient agrees in writing to remove it.
  - The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to request a paper copy of this notice.

*I hereby acknowledge that I have been given the right to review this organization's Privacy Practices and give my consent to use my protected health information under the conditions provided.*

\_\_\_\_\_  
Patient (Guardian) Signature

\_\_\_\_\_  
Date:

**OFFICE USE ONLY**

I attempted to obtain the patient's signature on this *Notice of Privacy Practices, Acknowledgment and Consent*, but was unable to do so as documented below:

Reason \_\_\_\_\_

Initials \_\_\_\_\_

Date \_\_\_\_\_