

BRIGHT FOOT CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Bright Foot Clinic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Bright Foot Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bright Foot Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bright Foot Clinic Privacy Officer at 1670 W. Sunset, Suite A, Springdale, AR 72762.

With this consent, Bright Foot Clinic may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Bright Foot Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

With this consent, Bright Foot Clinic may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements. I have the right to request that Bright Foot Clinic restrict how it uses or disclosed my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to BRIGHT FOOT CLINIC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BRIGHT FOOT CLINIC may decline to provide treatment to me.

Patient Name

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date