PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Long Island Orthotics & Prosthetics** may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Long Island Orthotics & Prosthetics** Notice of Privacy Practices for 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. **Long Island Orthotics & Prosthetics** 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 **Long Island Orthotics & Prosthetics** Privacy Officer.

With my consent, **Long Island Orthotics & Prosthetics** may call my home or other designated 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 appointment reminders, and insurance items and return calls requesting a call back.

With my consent, **Long Island Orthotics & Prosthetics** may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, **Long Island Orthotics & Prosthetics** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Long Island Orthotics & Prosthetics** restrict how it uses or discloses 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 **Long Island Orthotics & Prosthetics** 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, **Long Island Orthotics & Prosthetics** may decline to provide treatment to me.

I am aware that **Long Island Orthotics & Prosthetics** will scan my files and store them electronically on a secured server off-site.

I wish to be contacted in the following manner (*check all that applies*):

Home Telephone: ( ) OK to leave message with detailed information
Work Telephone: ( ) OK to leave message with detailed information

List any family member we may release medical information to:

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

_____	_____	_____
Patient's Signature	Print Patient's Name	Date
_____	_____	_____
Legal Guardian's Signature	Print name of Legal Guardian	Date