Dr Russell M Blatstein

(772) 225 – 3668
1635 NE Jensen Beach Blvd
Jensen Beach, FL 34957
Fax (772) 334 – 4115

(772) 337 – 2920
1226 SE Port St Lucie Blvd
Port St Lucie, FL 3495
Tax ID 59 – 2591195

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Russell Blatstein DPM PA which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice had made a good-faith effort to obtain an acknowledgement of _____(patients name) receipt[t of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ❑ Patient Unavailable
- ❑ Patient Physically Unable
- ❑ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ❑ Personally
- ❑ Mail
- ❑ Phone Follow-up
- ❑ Other _____

_____ _____

Date Signature

_____

Print Name

Dr Russell M Blatstein

(772) 225 – 3668
1635 NE Jensen Beach Blvd
Jensen Beach, FL 34957

(772) 337 – 2920
1226 SE Port St Lucie Blvd
Port St Lucie, FL 34952

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ consent to Russell Blatstein DPM, PA. To use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that related to my past, present, or future physical or mental health or condition; the provision of health care to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binging on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority