Robert L. Potempa, D.P.M.
Notice of Privacy Practice

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of ____ (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed and have been given the right to review Notice of Privacy Practices prior to signing this consent. I understand this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Authorization of Payment & Medical Information

I authorize payment of medical benefits to physician for services provided and release of medical information necessary to process claims. I understand I am fully responsible for any remaining balance.

PATIENT NAME:_____

SIGNATURE:_____DATE:_____

RELATIONSHIP TO PATIENT:_____