



176 Falls Ave Ste 200
Twin Falls, ID 83301
PH: 208-731-6321

HIPAA ACKNOWLEDGMENT

You, the patient or representative, agree to permit your protected health information to be used and disclosed for purposes of treatment, payment, research, and health care operations. For more details about these uses and disclosures, please see our Notice of Privacy Practices. We reserve the right to change our privacy policies described in the Privacy Notice. You may request a copy of our Privacy Notice at any time. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, research, and, or health care operations. We are not required to agree with this request, but if we do, we are bound by it. You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have acted in reliance upon the use of disclosure of your information. You will receive a copy of Advanced Foot Ankle's Privacy Policy Notice upon request.

Release of Information:

Advanced Foot & Ankle is required by law to create and maintain medical records regarding your care and to safeguard those records. Access to these records is limited to individuals involved in providing, coordinating, evaluating, or improving healthcare services, as well as those responsible for maintaining such records, in accordance with applicable law. By receiving services, you authorize Advanced Foot & Ankle to use and disclose your medical information as described above and in the Notice of Privacy Practices. You also authorize the release of necessary medical and claims information to insurance companies and other third parties for payment purposes. You have the right to access your medical records. A fee of \$1.00 per page may be charged for additional copies.

Phone Message Consent:

You authorize Advanced Foot & Ankle to leave messages concerning appointment, accounts, and healthcare on voice mail, and/or with persons answering phone numbers listed on your account, and/or with persons listed as alternate contacts on your account.

Consent for X-Rays:

You consent to the performance of x-rays which the physician of Advanced Foot & Ankle may consider necessary or advisable. You accept the risk of exposure to x-rays in hopes of obtaining desired beneficial health care results.

I, the patient or representative, acknowledge that I have received or have been offered a copy of this clinic's Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____ **Witness:** _____

If signed by representative:

Name: _____ **Relationship:** _____