RAPPAHANNOCK FOOT & ANKLE SPECIALISTS

Consent/Acknowledgement - Use and Disclosure of Protected Health Information

I understand that Rappahannock Foot and Ankle Specialists, PLC may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 371-2724.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

In order for Rappahannock Foot & Ankle Specialists, PLC to disclose Protected Health Information to someone other than you, you must complete this authorization.

_____ _____

Name of Patient (Please Print) **Date of Birth**

May we contact you by: **Email -** Yes / No **Text:** Yes / No

I authorize Rappahannock Foot & Ankle Specialists, PLC to disclose information on my health care to the following person(s).

( ) Spouse_____
( ) Other (please identify) _____

This authorization is valid until:

( ) _____date/event ( ) One year from date I sign this form
( ) Indefinitely

Person to Call if Unable to Reach You

Name: _____

Relationship: _____ Phone #: _____

Authorized Person(s) to Speak with Regarding My Account:

( ) Spouse_____
( ) Other (please identify) _____

I have the right to revoke this form at any time by submitting a cancellation authorization in writing to Rappahannock Foot & Ankle Specialists, PLC.

_____	_____	_____
Patient or Legal Surrogate	Date	Relationship to Patient

_____	_____
Witness	Date

195 Falcon Drive, Fredericksburg, VA 22408 ** Phone: (540) 371-2724 ♦ Fax: (540) 371-5072
450 Garrisonville Road, Ste 115, Stafford, VA 22554 ** Phone: (540) 720-0674 ♦ Fax: (540) 720-8044