SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
the attached Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient you have the right:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information,
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the office copy of the Notice of Privacy Practices for the person or persons whom you may contact.

COSHOCTON FOOT HEALTH CENTER
DR. DON TUPPER, PODIATRIST
1529 Walnut St., P O Box 728
Coshocton, OH 43812
Phone: 740-622-8400 Fax: 740-622-8437

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I was provided a copy of Coshocton Foot Health Center's Notice of Privacy Practices
(Print patients name) and that I have read (or had the opportunity to read if I so chose) and understood the Notice
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*_____ *_____
(Signature of patient or patient representative) (Date)

_____
(Personal representative's printed name and relationship to patient)

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing this section you authorize us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities as read and understood in the Notice of Privacy Practices.

*_____ *_____
(Signature of patient or personal representative) (Date)

_____
(Personal representative's printed name and relationship to patient)

REVOCATION OF PROTECTED HEALTH INFORMATION (PHI)

By signing below you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. The revocation also does not negate any of our prior actions while acting under your consent.

_____ _____
(Signature of patient or patient's personal representative) (Date)

_____
(Personal representative printed name and relationship to patient)

OFFICE USE ONLY

On_____, an acknowledgement of Receipt of privacy Practices form was delivered.
(Date)
This form was not signed due to:
- o Communication barriers which prevented acknowledgement
- o An emergency which prevented acknowledgement
- o Refusal to sign
- o Other_____

Office Assistant :_____

You are entitled to a copy of this authorization