Foot & Ankle Clinic

Of Central Nebraska

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have a right 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.

I understand your Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information and a complete copy is available upon request. I understand that this organization has the right to change its Notice of Privacy Practices.

Patient Authorization for Disclosure of Protected Health Information

I authorize the Foot & Ankle Clinic of Central NE to disclose protected health information concerning my medical care to the following individuals:

Please list below the name(s) and relationship of the individual(s) we may disclose information to. NOT PHYSICIANS, CLINICS, HOSPITALS OR OTHER HEALTHCARE PROVIDERS

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_____

This authorization shall be in force until advised otherwise in writing by the Patient or Personal Representative at which time this authorization to disclose PHI expires.

_____ _____

Signature of Patient or Patient Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority