Jacob B. Goldstein, DPM, LLC

HIPAA Statement - Notice of Privacy Practices

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Jacob B. Goldstein, DPM, LLC (The Company) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Jacob B. Goldstein, DPM, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Company reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jacob B. Goldstein, DPM, LLC 230-C East Main Street Gardner, KS 66030.

With this consent, The Company may call my home or other alternative location I designate and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, over due invoices, among others. However, our policy is not to leave detailed messages regarding PHI or anything related to treatment, payment, or healthcare operations.

With this consent, The Company may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

The Company will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes releasing your protected health information for the coordination and management of your healthcare to another health care provider, a home health agency, or laboratory.

The company will share your PHI with third-party “business associates” that perform various activities such as billing or transcription services for our practice. These companies, in turn, will be contracted to protect the privacy of your PHI.

The company may use or disclose your PHI to the extent that the use or disclosure is required by law such as a court subpoena, public health authority requirement, law enforcement requirement, coroner or funeral director requirement, Worker’s Compensation requirement, or any government or military department requirement.

I have the right to request that Jacob B. Goldstein, DPM, LLC restrict how it uses or discloses my PHI to carry out TPO. However, The Company is not required to agree to
my requested restrictions, but if it does it is bound by this agreement.

By signing his form I am consenting to Jacob B. Goldstein, DPM, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Jacob B. Goldstein, DPM, LLC may decline to provide treatment.

I have the right to complain to The Company or the Sec. of Health and Human Services if I believe my privacy rights have been violated by The Company. The Company will not retaliate against me for filing a complaint. I may also contact Dr. Goldstein. If I have any other questions about privacy practices.

I am entitled to a copy of this authorization upon my request.

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Signature of Patient or Legal Guardian Date

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Print Name of Patient or Legal Guardian