PAUL S. SCHWARTZ
SURGERY, DISEASES AND INJURIES OF THE FOOT AND ANKLE, SPORTS MEDICINE

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PATIENT NAME _____ BIRTHDATE:_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please refer to "Notice of Privacy Practices" Brochure, refer to the "Request Restrictions" section. This brochure is available in the office .

Please answer the following 2 questions:

I request the following restrictions to the use or disclosure of my health information:

#1 Medical Information can be discussed with

- ☐ Patient only
- ☐ Family member or friend
  Please List Name/Relationship

_____

_____

_____

_____

_____

- ☐ Physician _____
- ☐ Other _____
- ☐ No Restrictions
- ☐ Other Restrictions _____

#2 Detailed messages regarding test results can be left on answering machine

- ☐ Yes Phone Number _____
- ☐ No

PATIENT:

_____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature

Relationship to Patient _____