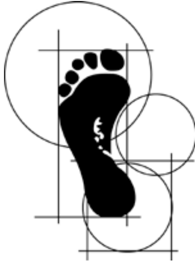

NORTHEAST WISCONSIN FOOT & ANKLE ASSOCIATES

Patient Consent for Use and Disclosure of Protected Health Information

By signing below, I agree to the following:

I acknowledge that I have received and been given the opportunity to review for Northeast Wisconsin Foot & Ankle Associates ("NEWFA") Notice of Privacy Practices which provides a more complete description of such uses and disclosures. I consent to NEWFA to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations, otherwise referred to as TPO.

I understand that a revised Notice of Privacy Practices may be obtained by forwarding a written request to: Northeast Wisconsin Foot & Ankle Associates Compliance Officer at 1301 East Northland Ave. Ste B; Appleton, Wisconsin 54911.

I consent to NEWFA calling my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

I consent to NEWFA mailing to my home or other alternative locations any items that assist the practice in carrying out TPO, such as statements, medical documents and notices.

I consent to NEWFA e-mailing me at the address provided any items that assist the practice in carrying out TPO, such as appointment reminders, medical documents and statements.

I authorize NEWFA to release my protected health information to the following individuals:
Name ________________________________ Relationship ________________________
Name ________________________________ Relationship ________________________

I understand I have the right to request that NEWFA restrict how it uses or discloses my PHI to carry out TPO. In some cases the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I may revoke my consent in writing 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, NEWFA may decline to provide treatment to me.

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Signature of Patient or Legal Guardian   Date:

____

Patients Printed Name