

**LOVELAND FOOT AND ANKLE CLINIC P.C.**

**dba ADVANCED FOOT AND ANKLE CARE**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Loveland Foot and Ankle Clinic, P.C. dba Advanced Foot and Ankle Care (AFAC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Loveland Foot and Ankle Clinic, P.C. 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. Advanced Foot and Ankle Care reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Foot and Ankle Care at 1440 N. Boise Ave. Loveland, CO 80538.

With this consent, Advanced Foot and Ankle Care may call my home or 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, calls pertaining to my clinical care, including laboratory results, and billing issues among others.

With this consent, Advanced Foot and Ankle Care may 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.

With this consent, Advanced Foot and Ankle Care may 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. I have the right to request that Advanced Foot and Ankle Care restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

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, Advanced Foot and Ankle Care may decline to provide treatment to me.

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**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize Advanced Foot and Ankle Care to use and/or disclose all medical protected health information (PHI) and billing information about me to or for the party or parties listed below, other than for information requested/required by your insurance company.

Name

Relationship

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When my information is used or disclosed following this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Advanced Foot and Ankle Care has acted in reliance upon this authorization. My written revocation, dated and signed, must be submitted to Advanced Foot and Ankle Care at 1440 N. Boise Ave. Loveland, CO 80538.

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Print Name of Patient or Legal Guardian

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Signature of Patient or Legal Guardian

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Date