Seacoast Foot Surgery Associates

Dr. James P. Wilton FACFAS, FASPS

CONSENT TO USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION (PHI)

My PHI which is the subject of this consent includes demographic information, Information about my physical or mental health condition, or condition, information about medical services provided to me, including payment information may be used to identify me. I understand, furthermore that the element of this consent are **<u>required by state and federal law for my protection</u>** and to ensure my informed consent to the use and disclosure and PHI necessary to support my relationship with **Seacoast Foot Surgery Associates.**

I consent to **Seacoast Foot Surgery Associates**

- Use and disclosure of my protected health information (PHI) in support of my diagnosis and treatment, payment for the medical services I receive, and the legitimate health care operations of the medical practice.
- Disclosure of PHI to other health care practitioners and facilities that are involved in providing medical services to me, my family and friends that who are providing me with emotional support as I receive my medical services.
- Disclosure of PHI to my health insurance carrier, utilization review organization, or third party administrator to support payment for my medical services.

I understand that **Seacoast Foot Surgery Associates**

- Agrees to provide medical services to me are conditional upon signing of this consent.
- Requests my consent to ensure that **Seacoast Foot Surgery Associates**. Can properly carry out the professional responsibility of caring for me.
- Will disclose only the minimum amount of my health care information which is necessary, in the judgment of **Seacoast Foot Surgery Associates** for the legitimate needs of the recipient or for my general well being.
- Regards the safeguarding of PHI as an important duty.

I understand that I have the right to:

- Restrict **Seacoast Foot Surgery Associates** use and discloser of my PHI and that **Seacoast Foot Surgery Associates** is not obligated to the requested restriction, but that an agreement to a restriction binds **Seacoast Foot Surgery Associates**.
- Revoke this consent at any time providing **Seacoast Foot Surgery Associates** with written, signed, and dated request expect to the extent that **Seacoast Foot Surgery Associates** has acted in the reliance upon my consent. However, I understand that any restrictions on the use and disclosure of PHI revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

Name: ______________________________ **Date:**____________________