

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT,
CONSENT TO PHOTOGRAPH, VIDEO AND/OR OBTAIN DIGITAL IMAGES,
And CONSENT TO SEND PRESCRIPTIONS ELECTRONICALLY**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to read the Notice of Privacy Practices, which is kept in the patient lobby and contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Jeffrey Fley Podiatry will retain ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the policy of Jeffrey Fley Podiatry. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give permission to Jeffrey Fley Podiatry to contact me by phone and it is ok to leave detailed messages related to my medical condition.

I authorize Jeffrey Fley Podiatry to discuss my medical history with the following people:

- ☐ spouse: _____
- ☐ children: _____
- ☐ other: _____

I agree that Jeffrey Fley Podiatry may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes and consent to the use of electronic prescribing as federally mandated.

Responsible Party's Signature

Date