CENTER FOR FOOT CARE ♦ DR. KRISTIN TITKO
ACKNOWLEDGMENT OF NOTIFICATION

Patient's Name:_____ Date of Birth: _____ Today's Date: _____

1. RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Center for Foot Care to release information to the following individual(s) (please provide name, relationship and contact number):

(1)_____

(2)_____ _____

(3)_____

2. ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICE

Please Check the Box Below that Applies:

☐ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

☐ I acknowledge that I was offered a copy of the Notice of Privacy Practices and I declined to take a copy.

_____ _____
Patient Name (please print) Date

_____ _____
Signature Parent or Authorized Representative (if applicable)

3. E-MAIL DISTRIBUTION WAIVER

WAIVER OF PRIVACY RIGHTS: FOR THE PURPOSE OF RECEIVING E-MAIL INFORMATION

It is the policy of the Practice to reserve the confidentiality and privacy of the protected health information of all our patients to the fullest extent permitted by law. Because of our Privacy Policy, this Practice will not use e-mail to send protected health information to our patients or to other third-parties without consent. The Health Insurance Portability and Accountability Act (HIPAA) requires consent to send such information to the email address identified on the patient registration form, where it might be seen by another person and reveal to that other person the protected health information. E-mail is not generally "secure" in the sense that others may have access to it. If you wish to receive your protected health information by e-mail, you must sign this waiver. The patrons under the age of 18 must also have their parent's consent on this form.

Date: _____ Signature: _____

I waive my right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) in order to receive the health care information above by e-mail. I understand that in doing so I relieve the Practice of all responsibilities for unauthorized access of protected health information while in transmission and upon delivery. I have the right to formally revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

If the individual is under 18 years of age, the parent or legal guardian must the following:

On behalf of the above named child, I _____ waive all rights to privacy under the Health Insurance Portability and Accountability Act (HIPAA) in order to receive the protected health information by e-mail.