Ambulatory Foot Center
Podiatric Medicine and Surgery
Adults and Children
Foot Specialists

1619 NW Hawthorne Ave. St 110
Grants Pass, OR 97526
(541) 471-7056 Fax (541) 474-3201

USE AND DISCLOSURE OF HEALTH INFORMATION

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information. We ask you to review our Notice of Privacy Practices that describes our legal duties to your health care.

How we use health care information:
We use information about you to:

- Provide treatment to you.
- Ensure appropriate payment for the treatment we provide, and
- Monitor the quality of your operation.

When we will disclose information:
In certain cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to your health or safety, for workers compensation, to reduce public health risk, for health oversights and in certain cases of law enforcement. In addition, we may disclose information to tell you about health related services and alternative treatments, and to conduct health-related research with your permission.

Your information right:
We create a record of the care we give you.

- You have the right to know how we use your health information, whom we give it to, and your right to this information.
- You have the right to ask us to restrict uses and disclosures where we believe such disclosures will not harm you and where it is possible for us to do so.
- You have the right to look at and get a copy of information in our record unless the doctor has indicate it would be harmful to you or someone else.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be confidential or for us to send a copy of your bill to a different address.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete information.
- You have the right to ask us for a list when we have disclosed your health information to someone other that those treating you, handling your bills, for internal operations, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have questions, please call and speak to the office manager at 471-7056.

Patient signature _____ Date _____