Authorization for Treatment and Release of Medical Information

PATIENT CONSENT FOR USE AND/OF DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Quantum Foot and Ankle Group Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Quantum Foot and Ankle Group to provide treatment to me, and also necessary Quantum Foot and Ankle Group to obtain payment for that treatment and to carry out health care operations. Quantum Foot and Ankle Group explained to me that the Privacy Notice will be available to me in the future at my request. Quantum Foot and Ankle Group has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Quantum Foot and Ankle Group reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that may be used by Quantum Foot and Ankle Group: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. Quantum Foot and Ankle Group may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Quantum Foot and Ankle Group to treat me and obtain payment for that treatment, and as necessary for Quantum Foot and Ankle Group to conduct its specific health care operations.
5. I understand that I have a right to request that Quantum Foot and Ankle Group restrict how my PHI is used.
6. I give my consent to have photographs, videotaped images, or other images made of me or minor dependent patient. I understand and agree that these images may be used by Quantum Foot and Ankle Group for the following purpose(s): teaching purposes, which includes being shown to other patients, advertisements by Quantum Foot and Ankle Group, and/or placement on Quantum Foot and Ankle Group website.
7. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Quantum Foot and

Ankle Group 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 Quantum Foot and Ankle Group policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

8. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that Quantum Foot and Ankle Group has already taken action in reliance on this consent.

9. **INSURANCE AGREEMENT:** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Quantum Foot and Ankle Group will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Quantum Foot and Ankle Group will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

10. **AUTHORIZATION AND ASSIGNMENT:** I request payment of government benefits to myself or to the party who accepts assignment. I authorize payment of medical benefits directly to Quantum Foot and Ankle Group for services to be rendered. The signature below allows Quantum Foot and Ankle Group to act on the patient's behalf as an authorized representative to appeal any health insurance claim or benefit recoupment utilizing HIPAA guidelines.

Name of Individual (Printed): _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):

_____

_____ _____

Signature of Individual Relationship

Date Signed _____/_____/_____ Witness:_____