

HARVEY LEFKOWITZ, D.P.M., P.C.

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
AND
ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES**

1. My "Protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby give my consent for Harvey Lefkowitz, D.P.M., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Harvey Lefkowitz, D.P.M., P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I understand that Harvey Lefkowitz, D.P.M., P.C. may refuse to diagnose or treatment, if I do not consent to the use or disclosure of my protected health information for the above stated purposes. (My signature on this document is evidence of this consent).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Harvey Lefkowitz, D.P.M., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Harvey Lefkowitz, D.P.M., P.C. Privacy Officer at 641 West Nine Mile Rd. Suite A, Ferndale, MI 48220.

With this consent, Harvey Lefkowitz, D.P.M., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Harvey Lefkowitz, D.P.M., P.C. may mail or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request that Harvey Lefkowitz, D.P.M., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to HARVEY LEFKOWITZ, D.P.M.,P.C.'s use and disclosure of my Protected Health Information (PHI) to carry out treatment, payment and healthcare operations (TPO)

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, HARVEY LEFKOWITZ, D.P.M., P.C. may decline to provide treatment to me.

I acknowledge that I was provided a copy of the Summary of 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 a full detailed copy of "Notice of Privacy Practices" is posted in the waiting room for my review. I am entitled to receive a full detailed copy of "Notice of Privacy Practices," and will be provided such copy by asking the receptionist for one.

Patient Name (Please Print)

Date

Parent or Authorized Representative (if applicable)

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding Notice of Privacy Practices

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;

- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to the Notice of Privacy Practices for the Privacy Officer, person or persons whom you may contact.