

Ankle and Foot Centers of Western New York

8745 Lake Street Road, LeRoy, NY 14482

Phone: 585-250-0064

Fax: 585-672-9100

Patient Consent for Use and Disclosure of Protected Health Information

(HIPPA)

I hereby give my consent for Dr. George R. Vito and the Ankle and Foot Centers of Western New York to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided by Dr. George R. Vito and the Ankle and Foot centers of Western New York describes such uses and disclosures more completely.

I have the right to review the Notice and Privacy Practices prior to signing this consent. Dr. George R. Vito and the Ankle and Foot Center of Western New York reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written consent to Dr. George R. Vito, 8745 lake Street Road, LeRoy, NY 14482.

With this consent, Dr. George R. Vito and the Ankle and foot Centers of Western New York may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With the consent, Dr. George R. Vito and the Ankle and foot Centers of Western New York may email my home or other alternative location any items that assist the practice in carrying gout TPO, such as appointment reminders cards, and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. George R. Vito and the Ankle and Foot Centers of Western New York may email to my home or other alternative location andy items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. George R. Vito or the Ankle and Foot Centers of Western New York, restrict how it uses or discloses my PHI to carry to TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow Dr. George R. Vito and the Ankle and Foot Centers fo Western New York to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already mede disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke, Dr. George R. Vito or the Ankle and Foot Centers of Western New York may decline to provide treatment to me.

Patient/Legal Guardian Signature: _____

Patient/Legal Guardian Print Name: _____

Date: _____