

**Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations as Mandated by Federal Law and Acknowledgement of Receipt of Notice of Privacy Practices**

I understand that I may obtain a copy of the **Notice of Privacy Practices**. This policy provides a complete description of information uses and disclosures. This policy may be obtained by requesting one from our front desk, or by accessing our office's website [www.gafootcare.com](http://www.gafootcare.com). I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that the offices of Paul V. Spiegl, M.D., P.C. and Perimeter Outpatient Surgical Associates are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. **I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.**

I further understand that the office of Paul V. Spiegl, M.D., P.C. and Perimeter Outpatient Surgical Associates reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I may obtain a revised *Notice of Privacy Practices* by accessing the office's website at [www.gafootcare.com](http://www.gafootcare.com), by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I wish to have the following restrictions to the use or disclosure of my health information:

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I fully understand and accept the terms of this consent.

\_\_\_\_\_  
Patient's Signature/Personal Representative

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

- ( ) Consent added to the patient's medical record on \_\_\_\_\_.
- ( ) Consent refused by patient, and treatment refused as permitted.