



Agoura-Los Robles Podiatry Centers

HIPPA PRIVACY PRACTICES

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office, home, or to family members of caretakers.

My signature below constitutes my acknowledgement that I have been advised of the HIPAA privacy rule.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

If not signed by patient, please indicate relationship: _____

Your medical records and health information are confidential and protected under HIPAA. We take the responsibility to secure your medical information seriously. Please advise us with whom we may share your information directly. No information will be given to any person unless they have your expressed authorization below:

Name <i>(please print clearly)</i>	Relationship	Phone Number

IN THE EVENT OUR OFFICE ATTEMPTS TO GET AHOLD OF YOU TO RELAY DIAGNOSTIC OR IMAGING RESULTS, PLEASE SHARE WHICH NUMBERS WE CAN LEAVE CONFIDENTIAL MESSAGES (IF APPLICABLE).

- Home telephone: _____
- Work telephone: _____
- Cell phone: _____
- Email: _____
- I **do not wish** to have messages left containing health information on any number