

**JAMES S. SCALES, DPM
WILLIAM F. HINESER, DPM, PC**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give my consent for William F. Hineser, DPM, PC (FootHealth, PC) to use and disclose protected health information (PHI) about me in order to carry out treatment, payment, and healthcare operations (TPO). (Our complete Notice of Privacy Practices provides a more complete description of such uses and disclosures and is available at our office or by forwarding a written request to William F. Hineser, DPM, PC at 7375 W 52nd Ave, Suite 350, Arvada, CO 80002.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. William F. Hineser, DPM, PC reserves the right to revise the Notices of Privacy Practices at any time. You may obtain revised Notices by contacting us as noted above.

With this consent, William F. Hineser, DPM, PC may call my home or other alternative locations 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 call pertaining to my clinical care, including laboratory results among others.

With this consent, William F. Hineser, DPM, PC may mail or e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders, health information, and patient statements. I have the right to request that William F. Hineser, DPM, PC restrict how it uses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to William F. Hineser, DPM, PC's use and disclosure of my PHI to carry out 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, William F. Hineser, DPM, PC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's Name

Print Name of Patient or Legal Guardian