NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHEEHY
ANKLE & FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ☐ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ☐ Obtain payments from third party payers.
- ☐ Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that your **Notice of Privacy Practices** contains a more complete descripTion of the uses and disclosures of my health information and a copy is available to me upon my request. I understand that Dr. Paul L. Sheehy, Jr., DPM of Sheehy Ankle & Foot Center of Tampa Bay has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Dr. Paul L. Sheehy, Jr., DPM of Sheehy Ankle & Foot Center of Tampa Bay to obtain a current copy of the **Notice of Privacy Practices** at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions.

The following is a listing of the person or persons (usually a spouse) whom I authorize to have access to my medical and billing records at this facility.

Name: _____ Relationship: _____

Signature: _____ Date: _____