Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I received a copy of the statement of privacy practices for the offices of Cascade Foot & Ankle. The Statement of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health-care operation. The statement of privacy practices also describes my rights and the responsibilities and duties of this office with respect to my health information. The statement of privacy practices is also posted in the facility.

Cascade Foot & Ankle reserves the right to change the privacy practices that are described in a statement of privacy practices. If privacy practices change I will be offered a copy of the revised statement of privacy practices at the time of my first visit after the revisions become effective. I may obtain a revised statement of privacy practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the statement of privacy practices, I herby specifically authorize disclosure of my protected healthcare information to the persons indicated below:

Any of my immediate family _____
Spouse only _____
Other (please specify) _____

_____ _____
Name of patient or personal representative Signature of patient or personal representative

_____ _____
Date Description of personal representative's authority

Office use below this line

Record of Acknowledgement not obtained

Provided prior to treatment? _____ Yes _____ No

Date provided: _____

Reason for denial: _____ Needed more time to review statement of privacy practices
_____ Wanted to consult with another person before signing
_____ Unable to sign
_____ Reason not given