

**Isidore Steiner, D.P.M., P.C.  
D/B/A Family Foot Center**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND  
ACKNOWLEDGMENT RECEIPT OF SUMMARY OF NOTICE OF PRIVACY PRACTICES**

My protected "health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby give my consent for Isidore Steiner, D.P.M., P.C. D/B/A Family Foot Center hereinafter referred to as Family Foot Center, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). **My signature on this document is evidence of this consent.**

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Foot Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Family Foot Center, Privacy Officer at 1221 Byron Road, Suite 3, Howell, Michigan 48843.

With this consent, Family Foot Center may call my home or other alternative location and leave a message on voice mail or in person with a relative in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results and specialized x-ray tests among others.

With this consent, Family Foot Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Family Foot Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Family Foot Center restrict how it uses or discloses my PHI to carry out TPO.

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

By signing this form, I am consenting to FAMILY FOOT CENTER'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, FAMILY FOOT CENTER may decline to provide treatment to me.

I acknowledge that I was provided a copy of the Summary of Notice Privacy Practices and that I have read or have had an opportunity to read if I so choose and understood this notice. I acknowledge that a full detailed copy of the "Notice of Privacy Practices" is posted in the waiting room for my review. I am entitled to receive a full detailed copy of the "Notice of Privacy Practices" and will be provided with such a copy by asking the receptionist for one.

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Legal Guardian**

\_\_\_\_\_  
**Email address for written communication**

\_\_\_\_\_  
**Address for written communication**

Phone Numbers for oral communication

**Home:** \_\_\_\_\_

**Work:** \_\_\_\_\_

**Cell:** \_\_\_\_\_

For Practice Use Only

Practice  Accepts  Denies

Privacy Officer Signature \_\_\_\_\_

Date: \_\_\_\_\_