FAMILY FOOT & ANKLE CENTERS OF SJ
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NOTICE OF PRIVACY PRACTICES & TELEPHONE COMMUNICATIONS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Family Foot and Ankle Center of South Jersey is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During health care operations, we may need to contact your primary care physician.

(See attached Notice of Privacy Practices for more detailed information)

We here at Family Foot and Ankle Center of South Jersey are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization in question. This written authorization may be revoked at any time by the individual, as provided for by law.

I acknowledge that I received a copy of FAMILY FOOT & ANKLE CENTER OF SJ Notice of Privacy Practices.

We value your right to privacy; therefore we would like you to determine how to handle our telephone communications with you. We routinely call patients for the following reasons:

- To confirm appointments.
- To relay test results.
- To reply to your questions and/or concerns.

If we attempt to contact you and you are not available, what would you like us to do?

☐ Leave a detailed message on an answering machine or voicemail.

☐ Leave a message with a call back number only on answering machine or voice mail.

HOME: _____ ***CELL:*** _____ ***WORK:*** _____.

☐ Do not leave information with any family member.

Do you give permission to discuss and release information in relation to your care with anyone? If so, who and also what is their relation to you?

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at (856) 667-8222.

I, _____, have read and understand the above Notice of Privacy Practices and HIPAA Communication.

Signed _____ ***Dated*** _____.
(Patient or Legal Guardian)

UPDATE YEARLY
Initial _____ Date _____ Initial _____ Date _____ Initial _____ Date _____