## FAMILY FOOT AND ANKLE SPECIALISTS OF THE CAROLINAS

### HIPAA Acknowledgement and Designation Disclosure Form

I. Acknowledgement of Practice's Notice of Privacy Practices: By signing below, I acknowledge I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

| **Name of Patient** | **Date of birth** | **Signature of patient/guardian** | **Date** |
|---|---|---|---|

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative: HIPAA states your personal health information (PHI) cannot be shared unless you give consent. You have the right to have one or more persons as a personal representative and you can limit the amount of information they receive. By signing and completing below you agree Family Foot and Ankle Specialists of the Carolinas may disclose your health information to the Personal Representative listed below as of the date given. This Personal Representative Designation will last until you tell Family Foot and Ankle Specialists of the Carolinas otherwise. To cancel this disclosure, you will have to sign a revoke form and disclosure will seize immediately but does not cancel disclosures given while this agreement was in effect. Family Foot and Ankle Specialists of the Carolinas will not cancel disclosures until signed written confirmation is received.

Print Name: _____ Relationship:_____ Date:_____

Print Name: _____ Relationship:_____ Date:_____

Print Name: _____ Relationship:_____ Date:_____

**I have read the policy in its entirety and agree to be bound by all terms and conditions herein.**

_____ _____

Print name of patient or Responsible Party Date

_____ _____

Signature of patient or Responsible Party Date