

# ROCHESTER PODIATRY

BOARD CERTIFIED PHYSICIANS & SURGEONS

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## Health Privacy Act

(Typed Policy at Front Desk for your review)

I, \_\_\_\_\_, hereby acknowledge receipt of Rochester Podiatry LLP's Notice of Privacy Practices. Rochester Podiatry LLP will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand Rochester Podiatry LLP has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.

I give my consent for Rochester Podiatry LLP to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Rochester Podiatry LLP.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_.  
If you are not the patient, please specify your relationship to the patient \_\_\_\_\_.

I make the following special request for confidential communications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |                |              |                     |
|----------------|--------------|---------------------|
| 1. Name: _____ | Phone: _____ | Relationship: _____ |
| 2. Name: _____ | Phone: _____ | Relationship: _____ |
| 3. Name: _____ | Phone: _____ | Relationship: _____ |