HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Dr. Felicia A. Johnson of Dynamic Foot Care will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Dr. Felicia A. Johnson of Dynamic Foot Care may use or disclose to provide treatment to you. We will also provide this information to subsequent health care providers. These individuals may create additional information related to the care and treatment they provide you. We are permitted by law to use your health information to obtain payment for our services. We are permitted by law to use your health information to perform our regular health care operations. In addition to these uses and disclosures, we may use your information to contact you to provide appointment reminders to you or to advise you of treatment alternatives available to you. We are permitted , and in some cases required, by law to make certain other disclosures of health information without your consent.

By signing this authorization you agree that Dr. Felicia A. Johnson of Dynamic Foot Care may disclose your personal health care information and in some case required, by law to make certain other disclosures of health information without your consent. If appropriate to the following entities under the following circumstances:

to public health agencies to satisfy certain reporting requirements, to health oversight agencies;

to any individual when ordered by a court or other legal process to do so;

to law enforcement officials when necessary for law enforcement purposes and required by law;

to a coroner or medical examiner when necessary to enable to perform their duties;

to organ procurement organizations, to enable them to make suitability determinations;

in case of emergency;

to researchers if their research has been approved by an institutional review board and they take certain steps to protect your privacy;

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to Dynamic Foot Care 791 White Pond Dr. Suite C, Akron, OH 44320. In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

Dynamic Foot Care will provide the patient with a copy of this signed authorization upon request.

Acknowledged and agreed to by:

PATIENT:

By_____ _____

Print Name_____ Date

Address:_____

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or, ON BEHALF OF PATIENT