

MARTIN J. FAASSE, D.P.M., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Martin J. Faasse, D.P.M., P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Martin J. Faasse, D.P.M., P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Martin J. Faasse, D.P.M., P.C. reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Martin J. Faasse, D.P.M., P.C.'s Privacy Officer at 3550 Fairlanes, S.W., P.O. Box 164, Grandville, MI 49468-0164.

With this consent, Martin J. Faasse, D.P.M., P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TOP, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Martin J. Faasse, D.P.M., P.C. 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 as long as they are marked Personal and Confidential.

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

However, the 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 Martin J. Faasse, D.P.M., P.C.'s use and disclosure, by voice, hardcopy, electronic media, or any other potentially acceptable method, 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, Martin J. Faasse, D.P.M., P.C. may decline to provide treatment to me.

I acknowledge that I have received the Notice of Policy Practices from Martin J. Faasse, D.P.M., P.C.

Signature of Patient or Legal Guardian

Legal Guardian Printed Name

Patient's Printed Name

Patient's Date of Birth

Date of Signature