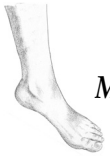

Kenneth M. Leavitt, DPM
Medicine & Reconstructive Surgery Of The Foot

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Due to the recent implementation of the Patient Privacy Act (HIPPA), it is necessary to obtain authorization for our office to leave messages at your home with family members and/or on answering machines, email, etc.

I hereby give my consent for Dr. Kenneth M. Leavitt and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

1. Dr. Kenneth M. Leavitt and staff'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. Dr. Kenneth M. Leavitt and staff reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to Dr. Kenneth M. Leavitt's office at New England Baptist Hospital, 125 Parker Hill Ave. Suite 390, Boston, MA 02120.
2. **PHONE CALLS:** Dr. Kenneth M. Leavitt and staff 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
3. **MAIL:** Dr. Kenneth M. Leavitt and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential.
4. **E-MAIL:** Dr. Kenneth M. Leavitt and staff may call my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
5. I have the right to request that Dr. Kenneth M. Leavitt and staff restrict how they use or disclose by 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.
6. I may revoke my consent in writing except to the extent that the practice has already may disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Kenneth M. Leavitt and staff may decline to provide treatment for me.

❑ I AUTHORIZE ❑ I DO NOT AUTHORIZE

✘_____ _____

Signature of Patient or Legal Guardian *Date*

_____ _____

Print Patients Name *If applicable Print Name of Legal Guardian*

FOR OFFICE USE ONLY:

❑ Consent received by _____ on _____

❑ Consent added to patient's medical record on _____

❑ Patient given copy of consent form on _____: ❑ in person ❑ via mail

❑ Consent refused by patient and treatment refused as permitted.