Georgia Foothills Hand Surgery
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Blue Ridge, GA 30513
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Web: www.georgiafoothillshandsurgery.com

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

With my consent, Dean D. Worthingstun, D.O. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dean D. Worthingstun, D.O. updated 2014 Notice of Privacy Practices for a more complete description of such users and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dean D. Worthingstun, D.O. reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to Rhonda Worthingstun, 980 E. Main Street, Suite 300, Blue Ridge, GA 30513.

With my consent, Dean D. Worthingstun, D.O. may call my home or other designated location and leave a message on voicemail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.With my consent, Dean D. Worthingstun, D.O. may mail to my home or other designated locations 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.

I have the right to request that Dean D. Worthingstun, D.O. restrict how is 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.

I acknowledge that I have a right to request copies of my PHI in a readily producible format. I am required to submit my request in writing designating the recipient and where to send a copy of the PHI. I acknowledge that a reasonable cost based fee for preparation may be charged to me by Dean D. Worthingstun, D.O.. I acknowledge and understand that Dean D. Worthingstun, D.O. has thirty days to address my request, with a one- time thirty day extension with written notice to me for reason of delay.

I acknowledge that I may submit a written request for Dean D. Worthingstun, D.O., to send to me unencrypted emails that may include ePHI. I acknowledge that certain risks are involved with receiving and sending unencrypted emails, and that my ePHI could be read by a 3rd party. I acknowledge that Dean D. Worthingstun, D.O. is not responsible for safeguarding information once it is delivered to me.

I acknowledge that I can submit a written request to restrict certain disclosures of PHI to health plans that meet the following criteria: 1.) The disclosure is to a health plan for purposes of carrying out payment or healthcare operations; 2.) The disclosure is not otherwise required by law; 3.) The PHI pertains solely to a health care item or service for which I, the individual, or a party other than the health plan, had paid Dean D. Worthingstun, D.O. in full.

I acknowledge that in the event of a security breach of PHI, Dean D. Worthingstun, D.O. will notify in writing those affected individuals.I acknowledge that Dean D. Worthingstun, D.O. does not engage in marketing, fundraising, or research and my PHI will not be sold without my permission for such purposes.

By signing this form, I am consenting Dean D. Worthingstun, D.O. use and disclosure of my PHI to carry out TPO. I am also giving my consent to Dean D. Worthingstun, D.O. to use my surgical notes or photographs for teaching purposes.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, Dean D. Worthingstun, D.O. may decline to provide treatment to me.

I have been offered a full copy of the updated 2014 Practices HIPPA Policies and Procedures for review.

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Patient/Guardian Signature Date