



Acknowledgement of Notice of Privacy Practices (HIPPA)

Dr. Wendy L. McFalda, in an effort to comply with HIPPA, has a Notice of Privacy Practices available to all patients in the reception area and with the receptionist.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Wendy L. McFalda may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Clarkston Dermatology & Vein Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Dr. Wendy L. McFalda reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to:

Wendy L. McFalda, D.O.
7210 North Main Street, Suite 103
Clarkston, MI 48346

With my consent, Dr. Wendy L. McFalda may call my home or other designated location and/or leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items or any call pertaining to my clinical care.

With my consent, Dr. Wendy L. McFalda may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Dr. Wendy L. McFalda may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, etc. I have the right to request that Dr. Wendy L. McFalda restrict how it uses or discloses my Protected Health Information to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Wendy L. McFalda use and disclosure any of my Protected Health Information 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, Dr. Wendy L. McFalda may decline to provide treatment to me.

I have read the above authorizations, acknowledgements, and policies. I understand them and agree to this as outlined.

Patient's Name (print) _____ **Signature** _____

Guardian's Name (print) _____ Relationship to Patient _____

Witness _____ Date _____