

NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Richard W Swails, DPM PC to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Richard W Swails DPM PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard W Swails DPM PC, Privacy Officer, 5337 W University Drive, Ste 100, McKinney TX 75071.

With this consent, Richard W Swails DPM PC 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. However, our policy is not to leave detailed messages regarding Protected Health Information or anything related to treatment, payment or healthcare operations.

With this consent, Richard W Swails DPM PC 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, Richard W Swails DPM PC may **e-mail to my home or other alternative location** any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements.

I have the right to request that Richard W Swails DPM PC 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.

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, Richard W Swails DPM PC may decline to provide treatment.

I acknowledge that I was provided a copy of the Notice of Privacy Practices. I have read and understand the notice. By signing this form, I am consenting to Richard W Swails, DPM, PC disclosure of my Personal Health Information (PHI) to carry out Treatment, Payment and healthcare Operations (TPO).

Patient Name

Responsibility Party Name (if different)

Signature of Responsible Party

Date

Notice of Privacy Practices Effective as of 7/19/2021