HIPAA PATIENT

CONSENT FORM

Capital City Foot & Ankle center

where our patients are our family

CAPITAL CITY FOOT & ANKLE Ctr

DR. IJAZ A. ZIA, DPM

1300 BENT CREEK BLVD STE # 101
MECHANICSBURG, PA 17050
Ph:- 717-697-2727
Fax:- 717-697-2884

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I also understand that this practice(Capital City Foot & Ankle Center LLC) is not required to agree to my requested restrictions, but if it does then Capital City Foot & Ankle Center is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that this Center has taken action relying on this consent.

Patient Name:____________________________________ ________________

Signature:____

Relationship to Patient(If other than patient):___________________________

Date:______________________