Katheryne W. Glantz, DPM

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Sparks, NV 89434

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Receipt of Notice Regarding Privacy of Personal Health Information (PHI)

I have received or have been provided with the opportunity to review a copy of the "Notice Regarding Privacy of Personal Health Information" that explains when, where and why my confidential health information may be used or shared. I acknowledge that Katheryne W. Glantz, Medical Assistant, staff and our billing agency may use and share my confidential health information with others in order to treat me, in order to arrange a form of payment of my bill and for issues that concern the practice's operation and responsibilities.

I further acknowledge that I understand that if I have any questions regarding this notice or wish to file a complaint, I may contact the practice's Privacy Officer listed below. I also understand that no other staff member, physician or medical assistant or any other person is authorized it accept a request to exercise my right but the Privacy Officer for the above-mentioned practice.

Privacy Officer, Katheryne W. Glantz, DPM

Patient Signature	**Date**	**Signature Parent/Guardian**	**Date**
Print name as signed above		**Print name as signed above**	

I authorize medical/financial information to be released to:

1)_____Relationship_____
2)_____Relationship_____

I wish to be contacted in the following manner:

Home Telephone_____
__Okay to leave a detailed message
__Leave a message with call back number only
Work Telephone_____
__Okay to leave a detailed message
__Leave a message with call back number only
Cell Phone_____
__Okay to leave a detailed message
__Leave message with call back number only
Written Communication
__Okay to mail to my home address
__Okay to mail my work/office address
__Okay to fax to this number_____