CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ E MAIL: _____

PATIENT NUMBER: _____ SOCIAL SECURITY # _____

SECTION B: TO THE PATIENT (PLEASE READ THE FOLLOWING STATEMENT CAREFULLY)

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES AND HEALTCARE OPERARATIONS OF THE USES AND DISCLOSURE WE MAY MAKE OF YOUR HEALTH INFORMATION AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THE CONSENT.

YOU RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF OUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING:

CONTACT PERSON: **(OFFICE MANAGER)**

TELEPHONE: **954-432-6133 OR FAX: 954-432-8989**

ADDRESS: **1541 N PALM AVE**
PEMBROKE PINES, FL 33026

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE

I, _____ HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOU USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE: _____ **DATE:** _____

IF THIS CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME: _____

RELATIONSHIP TO PATIENT: _____