Specializing in the Practice of Surgery
1890 LPGA Boulevard, Suite 250
Daytona Beach, Florida 32117
Phone: (386) 274-0250
Fax: (386) 274-0269

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to North Florida Surgeons Volusia Division and all health care providers furnishing care within the proactive to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or conditions and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review or Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our central billing office at (904) 369-1725.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf by an individual with legal authority, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we receive the revocation. Your revocation will not be effective to the extent that others or we have acted in reliance upon this consent.

Patient signature: _______________________________________ Date: ____________________

Patient name of patient: __________________________________

Legal guardian/representative: ______________________________ Relationship: ________________