



CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

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The Patient hereby consents to the use or disclosure of his/her individually identifiable health information (“protected health information”) and patient medical record information by Orlando Neurosurgery (the “Practice”) in order to carry out treatment, payment, or health care operations. The Patient should review the Practice’s Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient’s requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient’s protected health information and patient medical record information to the following individuals who are either the Patient’s family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

The Patient agrees that the Practice may disclose the following types of information contained in the Patient’s medical records (please initial the appropriate categories listed below):

- HIV/AIDS Information
- Mental Health Information
- Substance Abuse Information
- Sexually Transmitted Disease Information
- If Patient is under the age of eighteen (18), Pregnancy Information

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At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____

Signature of Patient (or Authorized Representative*)

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

