

Florida Neurology Group, P.L.

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**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Florida Neurology Group may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Florida Neurology Group’s “Notice of Privacy Practices” for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Florida Neurology Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Florida Neurology Group’s Privacy Officer at 12670 Whitehall Drive, Fort Myers, Florida 33907.

With my consent, Florida Neurology Group may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Florida Neurology Group may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statement.

I have the right to request that Florida Neurology Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Florida Neurology Group’s use and disclosure of my PHI to carry out TPO.

This is a lifetime consent, however I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. My written revocation must be submitted to Privacy Officer at 12670 Whitehall Drive, Fort Myers, Florida 33907.

If I do not sign this consent, Florida Neurology Group may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient’s Name

Print Name of Patient or Legal Guardian

Date