AUTHORIZATION TO RELEASE OR USE INFORMATION OF TREATMENT, PAYMENT, OR HEALTH CARE OPTIONS

NAME: ____ D.O.B: __________________

I hereby authorize the release or use of my individually identifiable health information "protected health information" and medical record information by Florida Infectious Disease Group, P.A.,(the "Practice") in order to carry out treatment, payment, or health care operations.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions, such are then binding on the Practice.

I acknowledge and agree that the practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf. Please explain Representative's relationship to the patient and include a description of representative's authority to act on behalf of the patient.

_________________________________ _________________________________

_________________________________ _________________________________

I acknowledge it is my responsibility as the patient to provide current, updated and correct insurance information to the practice for proper submission to my insurance Company. Failure to provide accurate information could result as patient responsibility for payment.

I agree and consent to the Practice releasing information to me in the following alternative manners

___ Via regular mail with any envelopes being marked personal and confidential and addressed to me.

___ Via telephone, if I contact the practice and provide the appropriate information (including my name, social security number and unique personal identifier).

I have read and understand the information in this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

____

Signature of patient or authorized representative

Date: _____/______/________