

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

Print Patient Name: _____ Date: _____

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by CFP Physicians Group, P.A. (the “Practice”) in order to carry out treatment, payment, or health care operations. You should review the Practice’s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice’s physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your PHI to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

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

I have been provided the opportunity to review the Practice’s Notice of Privacy Practices in the waiting room and I understand I may receive a copy if I request it.

Patient Signature: _____

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals: **(please initial line and write in name of individual)**

Spouse _____ Parent _____
 Child _____ Legal Guardian _____
 Other _____ Power of Attorney _____

I agree that the Practice may also disclose the following types of information contained in my medical record. **(please initial below):**

Substance Abuse Information	HIV / AIDS Information
Sexually Transmitted Disease Information	Mental Health Information
Pregnancy Information if patient is under 18 years old.	

I agree and consent to the Practice releasing information to me in the following alternative **manners (please initial the appropriate spaces below):**

Via regular mail Via telephone
 Via home answering machine Via work voice mail
 Via fax to my designated fax number which is: _____

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

