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

Print Patient Name: _____ Date: _____

Print Name of Parent/Legal Guardian/Authorized Representative: _____

I hereby authorize the release or use of my/ or the patient's individually identifiable health information ("protected health information") and medical record information by CFP Physicians Group, P.L.© (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/ the patient's care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your protected health information 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, in writing, that we further restrict how your/ the patient's 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, in writing, to your/ the patient's requested restriction(s), such restrictions are then binding on the Practice.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided, either in electronic or written format, a copy of CFP Physician Group's Notice of Privacy Practices.

Signature of Patient or Authorized Representative: _____

I acknowledge and agree that the Practice may disclose my/the patient's 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/the patient's medical record unless initialed below. **(Please initial to EXCLUDE)**

	Substance Abuse Information		HIV/AIDS Information
	Sexually Transmitted Information		Mental Health Information
	Genetic Testing		Other:

I agree and consent to the Practice releasing information to me in the following alternative manners *unless initialed to exclude* being contacted in any of these below.

	Via regular mail		Via telephone		Via email

I have read and understand the information in this consent. I am aware I can request a copy of this consent. I agree that I am the patient or the authorized party to act on behalf of the patient to sign this document.

Signature of Patient (or Authorized Representative) _____

Print Name: _____Date: _____