PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, University Family Medicine Center, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to University Family Medicine Center, PA'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. University Family Medicine Center, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to University Family Medicine Center, PA Privacy Officer, Janet Burns, at 10055 University Blvd., Orlando, FL 32817.

With my consent, University Family Medicine Center, PA may call my home or other designated location and leave a message on a 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.

With my consent, University Family Medicine Center, PA 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 statements.

I have the right to request that University Family Medicine Center, PA restricts 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 University Family Medicine Center, PA's uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already disclosures in reliance upon my prior consent. If I do not sign this consent, University Family Medicine Center, PA may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Release of Information to: Spouse, Children or Other

I give authorization for University Family Medicine Center, PA to **Discuss/ Release** my information including: diagnosis, records, examination rendered to me and claims information.

_____	_____	_____
Name	Relation	Date
_____	_____	_____
Name	Relation	Date