

INSTITUTE OF SPORTS MEDICINE AND ORTHOPAEDICS, P.A.

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

SECTION A: Patient Giving Consent

Name _____

Address _____

Telephone _____ Social Security _____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Institute of Sports Medicine and Orthopaedics, P.A.
Address: 20295 N.E. 29th Place, Suite 300, Aventura, FL 33180
Telephone: (786) 629-0910 Fax: (786) 629-0920

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature.

I, _____ have had full opportunity to read and consider the contents of this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature _____ **Date** _____

20295 N.E. 29th Place • Suite 300 • Aventura, FL 33180 (786) 629-0910, Fax: (786) 629-0920