PRIMARY CARE PHYSICIANS of Gainesville

3780 NW 83rd Street
Gainesville, FL 32606

2019 Consent to Use and Disclose Health Information

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Official in this office.

I _____, currently residing at _____

of (city) _____, (country) _____, (state) _____
do hereby consent to the use and disclosure of any individually identifiable health information ("Health Information") by Primary Care Physicians of Gainesville ("Provider") for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Provider, and/or engaging in health care operations, such as office management, credentialing case management, and quality assessment.

I understand that the Provider's Notice of Privacy Practices ("Notice") describes in more detail the types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and I have a right to review such Notice prior to signing this consent.

I understand that the Provider has reserved the right to change the privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to Provider.

I understand that if I decline to sign this consent, Provider may withhold medical services, other than emergency services.

I understand that I have the right to request restriction on Provider's use or disclosure of any and/or all Health Information to any and/or all locations, entities or persons. I further understand that Provider is not obligated to agree to my request, however, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

_____ _____
Patient Signature Date

Request for Confidential Communication of Protected Health Information

The mailing address for communications for Primary Care Physicians of Gainesville is the same address on my update sheet. _____
Initial

The following persons may receive and discuss information regarding my healthcare:

_____ _____
Name Phone

_____ _____
Name Phone

The following phone numbers are approved to leave messages regarding my health care and test results:

_____ _____ _____
Phone Phone Phone

The pharmacy I prefer for my prescriptions: _____

Signature: _____