CENTRAL FLORIDA PAIN & REHAB CLINIC
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CONSENT TO DISCLOSURE INFORMATION

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I _____ , understand that as part of my health care, **Central Florida Pain & Rehab Clinic** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication between the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that gives a complete description of information uses and disclosures. I understand that I have the following right and privileges:

- The right to review the notice prior to signing this consent.
- The right to object the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that **Central Florida Pain & Rehab Clinic** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extend that the organization has already taken action in reliance there on. I also understand that by refusing to sign or revoking this consent, this organization may refuse to treat me as permitted by **Section 164.506** of the **Code of Federal Regulations**.

I further understand that **Central Florida Pain & Rehab Clinic** reserves the right to change their notice and practices and prior to implementation, in accordance with **Section 164.520** of the **Code of Federal Regulations**.
Should **Central Florida Pain & Rehab Clinic** change their notice, they will send a copy of any revised notice to the address I have provided, (whether U.S. mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I finally understand and accept the term of this consent.

_____ _____

Patient Signature Date

Spanish Version: Por motivos legales el consentimiento del paciente debe estar consignado en este documento en inglés, pero si usted no tiene claridad con respecto a algo aquí relacionado, favor solicite la versión en español del mismo a nuestro personal.