Patient Consent Form

BREVARD RHEUMATOLOGY & ARTHRITIS CENTER

I understand under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Obtain payment from third-party payers

• Conduct normal healthcare operations such as quality assessments and physician

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. certifications I have been informed by you and your Notice of Privacy Practices containing a more complete description about the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Signature:_____

Date:_____