Sher Allergy Specialists

A division of Florida Pediatric Associates, LLC

Patient Consent for Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations, Per HIPAA Regulations

I understand that as part of my healthcare, the practice originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered

A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
I have been provided with a "*Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following and privileges:

- The right to review the "*Notice*' prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

Please Print

Restrictions;
I request the following restrictions to the use or disclosure of my health information:
_____
_____
Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))
_____
_____

Messages or Appointment Reminders
May we leave a message at your home using doctor's /practice name: ☐ Yes ☐ No
May we leave a message at your work using doctor's /practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and ☐ accept ☐ decline the information of this consent.

_____ _____

Patient/ Guardian Signature Date

_____

Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No