

Dr. Robert G. Rosen

Brevard Podiatry

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**Consent to Use or Disclose Information for
Treatment, Payment, or Health Care Operations**

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Brevard Podiatry, (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's request restriction(s), such restrictions are then binding the Practice.

At all times, Patient retains the right to revoke this Consent. Such revocations must be submitted to the Practice's Privacy Officer in writing. The revocation shall be effective except to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO. ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____ AM/PM

Signature of Patient (or Authorized Representative*)

Please Print Name

1/2019

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