INDIAN RIVER PRIMARY CARE

Curtis Dalili, MD
Thomas W. Lewis, MD
William A. Arnold, MD

1715 37th Place, Second Floor **Telephone 772-794-2222**
Vero Beach, Florida 32960 **Fax 772-794-0045**

PATIENT'S CONSENT

For use and disclosure of Protected Health Information - To carry out Treatment,
Payment, or Health Care Operations

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Name of Patient

Indian River Primary Care
Name of Health Care Provider

I agree to allow the listed health care provider to use or disclose the protected health care information to carry out treatment, payment, or health care operations.

I have been informed of the existence of the Privacy Notice. The Notice is a more complete description of the uses and disclosures of protected health information that may be made, and of my rights with respect to protected health information.

- I understand that I have the right to review the Notice before signing this Consent.
- I understand that I have the right to request a copy of the Notice.
- I understand that the terms of the Notice may change, and that I have the right to request a revised copy of the Notice.

I understand that I have the right to request a restriction on how protected health information is used or disclosed to carry out for treatment, payment and health care operations. This request for restriction must be in writing. If the health care provider agrees to the restriction, the restriction is binding. However, the health care provider is not required to agree to a requested restriction.

I understand that I have the right to revoke this Consent at any time. This revocation must be in writing.

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Signature of patient, legal guardian, or personal representative

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Date