FLORIDA HAND CENTER
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CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION, ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT'S BILL OF RIGHTS

I hereby give consent to Stephen L. Helgemo, Jr., M.D., P.A., and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment, and health care options.

My "Protected Health Information" mean health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer at (941) 625-6547. You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care options. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and be delivered to the above address. You may deliver your revocation by any means you choose; but, it will be effective only when we receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

In addition, no form or use of recordings is permitted while on the Florida Hand Center property.

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices as well as the Patient's Bill of Rights and Responsibilities.

Date: _____
Signature: _____
Printed Name: _____

If you are signing as the Patient's Representative: _____
Describe your authority: _____

PLEASE LIST ANYONE <u>INCLUDING</u> Spouse, Partner, Relative, or Sibling THAT YOU WOULD LIKE TO HAVE PERMISSION TO GET YOUR PRIVATE HEALTH INFORMATION.

1) _____
2_____
3) _____