Acknowledgement of Privacy Practice, Consent For Treatment And Health Care Operations

I consent to the use or disclosure of my protected health information by Greater Orlando Medical Weight Loss for the purpose of diagnosing or providing treatment to me or my child, obtaining payment for my or my child's health care bills or to conduct health care operations of Greater Orlando Medical Weight Loss.

I have the right to revoke this consent, in writing, at any time, except to the extent that Greater Orlando Medical Weight Loss has taken action in reliance on this consent.

My / my child's "protected health information" means 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 / my child's past, present or future physical or mental health or condition and identities me / my child, or there is a reasonable basis to believe the information may identify myself or my child.

Greater Orlando Medical Weight Loss has an established privacy policy which is displayed in this office and I can request a printed copy of this policy. I _____ have reviewed/received a copy of Dr. Cruz's
Print Your Name
G.O. Notice of Privacy practices.

ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

I WISH TO BE CONTACTED IN THE FOLLOWING. MANNER REGARDING APPOINTMENTS, TELEPHONE TRIAGE, INSURANCE/BILLING ISSUES, LAB RESULTS, ETC.

Home Telephone _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

Written Communication

☐ OK to email

☐ OK to mail to my home address

☐ OK to fax to this number _____

I authorize the release of medical information to the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

I have read and understand the above information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on behalf of myself or the patient to sign this document verifying consent to the above terms.

_____ _____

Signature of Patient or Parent / Guardian | Name of Patient (Print)

_____ _____

Witness | Date