PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)**
- **Obtaining payment from third party payers (e.g. my insurance company)**
- **The day-to-day healthcare operations of your practice.**

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my Protected Health Information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, and that you are not required to agree with these restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize the following friends/family to retrieve/discuss my medical condition in my absence. Without their names on this list, Florida Wellness Group WILL NOT be allowed to release ANY information. I can refuse to sign this form, or revoke it any time by completing a new form. I understand that if information is shared with the below individuals it may be subject to exposure by the individual.

Name: _____ Relationship: _____
Name: _____ Relationship:_____

Printed Name: _____

Signature: _____

Date: _____

Relationship to patient: _____