CONSENT OF DISCLOSURE
For the Usage and/or Disclosure of Protected Health Information

I hereby give consent to Spine & Orthopedic Center, P.A. and all health care providers furnishing care within Spine & Orthopedic Center, P.A.'s facilities, to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf by an authorized person, and delivered to the address at the bottom of this form. This notification of cancellation may be delivered in person or by mail, effective on the date received. Your cancellation will not be effective to the extent that we or other persons have acted in reliance upon this request.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us. You may need to file and receive usage of your protected health information from any and all other health providers with access to your protected health information.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling 813 224-9222 or by mail request.

Print Name of Patient: _____

Signature:_____ Date _____

If you are signing as the patient's representative:

Print Your Name:_____ Relationship _____

I; _____, direct my health care and medical services providers to disclose and release my protected Health Information to:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

CANCELLATION

I hereby void the consent given above

Print Name of Patient _____

Signature of Patient _____ Date _____

If you are signing as the patient's representative

Print Your Name _____ Relationship _____

Address for cancellation:
Your cancellation will be effective upon receipt at the following address: 812 W. Dr. MLK Jr., Blvd, #201 Tampa, FL 33603

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