CARLOS R. SANTOS MD., PA

CONSENT FOR DR. CARLOS R. SANTOS MD., PA TO USE OR DISCLOSURE HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with State of Florida and Federal law concerning the privacy of such information. **Failure to provide all information requested may invalidate this authorization.**

I hereby authorize Dr. Carlos R. Santos MD., PA to use or disclosure of my health information as follows:

Name _____
Address _____
Telephone _____

To the patient-Please read the following statements carefully.
Purpose of Consent. By signing this form, you will consent to our use and disclosure of your unprotected information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information and of other important matters about our protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right change our Privacy Practices and described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Karina Robles**
Telephone: (305) 653-0425 ext. 7 Fax: (305)653-4055

Right Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you or to continue treating you if you revoke this consent.

SIGNATURE
I, _____, have had fully opportunity to read and consider the consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to you use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: _____
Date: _____

16855 NE 2Avenue, Suite 302A North Miami Beach, FL 33162
PHONE (305) 653-0425
FAX (305) 6534055