JUPITER HEMATOLOGY & ONCOLOGY ASSOCIATES

SERVING OUR COMMUNITY FOR 28 YEARS

ELIZABETH A. REICH, M.D. HENRY J. SHAPIRO, M.D. JUAN E. SANCHEZ, M.D ANDRES E. CANOVA, M.D.

Patient Consent to the Use of Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, ______________________________ understand that as part of my health care, this facility originates and maintains paper/ and or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare Professionals.

I understand and have been provided with NOTICE OF PRACTICES that provides a more complete description of Information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that this facility is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that this facility, reserves the right to change their notice and practices and prior to implementation, in Accordance with Section 164.520 of the Code of Federal Regulations. Should this facility, change their notice, they will send a Copy of any revised notice to the address I have provided.

I wish to have the following restrictions to the use of disclosure of my health information. (Include people you do not want access to)

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I understand that part of this organization' treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

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I authorize this facility to discuss my treatment, payment and healthcare operations with:

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I understand that some of my treatments may occur in open areas therefore limiting this security of my information. I fully understand and accept/decline the terms of this consent.

Patient Signature	Date:

BERMUDIANA
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