# CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: _____

Patient's Date of Birth:_____ Patient's SSN:_____

**Notice to Patient:**
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, I acknowledge that I have been given the opportunity to obtain one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it. ***Your consent if valid for one year from the date below.***

*(To Be Completed by Patient or Patient's Representative)*

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations. This consent is valid for one year from the date below.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

**Our Privacy Officer can be contacted as follows:**

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|---|---|---|
| Name of Privacy Officer: Polly Bittle, APRN, FNP-C | | |
| Practice Address: Tampa Bay Nephrology Associates, P.L.<br>4912 N. Armenia Avenue<br>Tampa, FL 33603 | | |
| Phone: 813-353-8775 | Fax: 813-353-3956 | E-Mail:<br>pbittle@tampabaynephrology.com |

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