HIPAA Authorization

I authorize the practice and its agents to disclose my protected health information among the practice, its agents and/or myself for the purpose of my care and treatment. I further authorize the practice to disclose my protected health information, including copies of applicable hospital and medical records and protected health information obtained prior to the date of this authorization to:

- Any third-party payer covering the medical services of the patient;
- Other health care professionals and institutions involved in the delivery of health care to the patient;
- The proponent of any legally sufficient subpoena, or in response to a court order;
- Employees, and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body to be used for medical records. In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I also hereby authorize the disclosure of personal health information to persons that I choose to accompany me in the office while examined.

The practice may contact me to remind me of my appointment or collect money that I owe via telephone, text message or email at any number or email given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that such communication may come by autodialing devices and through pre- recorded messages, artificial voice messages or voicemail messages. I may opt out of these communications in writing at any time.

In granting this authorization, I understand that:

1. The term "protected health information" is individually identifiable information about the patient that includes the past, present or future healthcare of the individual and is transmitted and/or stored by a covered entity or business associate.

2. I have been given access to the Practice's Notice of Privacy Practice.

3. I have had the opportunity to place special restrictions upon the consent hereby given.

4. I have the right to revoke this authorization at any time in writing to 900 Village Square Crossing Ste 290, Palm Beach Gardens, FL., 33410

5. I may revoke this authorization except to the extent that information has already been disclosed based on this authorization.

6. Signing this authorization is voluntary. I agree that treatment may be denied if I do not authorize this release of protected health information.

7. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I also hereby authorize the disclosure of personal health information in the following manners and to the following persons:

Initial if okay to leave a message on voicemail: _____

E-Mail to the following address: _____

To the following individual:

1. Name: _____ Relation to Patient: _____

   Phone: _____

2. Name: _____ Relation to Patient: _____

   Phone: _____

3. Name: _____ Relation to Patient: _____

   Phone: _____

_____ I do not want my personal health information disclosed to any other parties.

Special Restrictions: _____

This executed authorization will be stored in your medical record and will be available to you upon request. A copy of this authorization is as valid as the original.

This authorization does not have an expiration date and will remain in effect until updated or revoked in writing.

_____ _____

Patient signature Date

_____ _____

Patient Name Printed Patient DOB