TENET FLORIDA PHYSICIAN SERVICES, LLC.

Authorization for Use and Disclosure of Individually Identifiable Health information and Confidential Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: Tenet Florida Physician Services, LLC. and its employees or contractors.
2. I acknowledge and agree that the practice may disclose my protected health information and information contained in my medical record to the following (check allowances) ☐Spouse ☐ Adult Children ☐All family members ☐legal representatives ☐ guardians ☐health care surrogates ☐ Other ________________________________, ☐**ALL LISTED.**
3. Specific information that may be used/disclosed: information relating to treatment, payment, and health care operations.
4. The information will be used/disclosed for: treatment, payment, and health care operations.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign, or my revocation this authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
8. I have read and agree to the information regarding "How We May Use and Disclose Medical Information About You." Our notice of "Privacy Practices" (posted in reception) provides information about how we may use and disclose health information about you. You have the right to review our notice before signing this form. The practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If so, the patient may obtain a copy of this revised Notice. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
9. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
10. Patient agrees and consents to the practice releasing information to the patient in the following alternative manners:
    ☐ Via Regular mail with envelope being marked personal and confidential, and addressed to the patient.
    ☐ Via telephone, if the patient contacts the practice and provides the appropriate information (name, SSN, Birth date).

The practice may refuse to treat the patient if he/she (or an authorized representative) does not sign this consent form. If the patient (or an authorized representative) signs this consent form, and then revokes it, the practice has the right to refuse to provide further treatment to the patient as of the time of revocation (except as the practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient, or am authorized to act on behalf of the patient to sign this document verifying consent of the above stated terms.

____ ____
Signature of patient or patient's representative Date