PATIENT/INSURANCE CONTACT FORM

Laida N. Casanova, M.D., LLC

Patient Name: _____ Home Phone: _____

Home Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____ Cell / Cellular: _____

Email: _____

Date of Birth: _____

Husband/Partner's Occupation & Employer: _____

Patient's Occupation & Employer: _____ Social Security #: _____

Emergency Contact: _____ Marital Status: _____

Phone Number: _____ Primary Doctor: _____

Pharmacy: _____ Referred by: _____

****

INSURANCE INFORMATION: MUST BE FILLED OUT BY THE PATIENT

(ALL NEEDED INFORMATION IS LOCATED ON THE FRONT & BACK OF INSURANCE CARD)

Name of Insurance: _____ Customer Service Number: _____

Claims Address: _____ Policy or I.D. Number: _____

Group #: _____ Company by which Insurance is Through: _____

Primary Holder of the Insurance plan: _____ **Holder's Date of Birth:** _____ **Relation to Patient:** _____

2nd Insurance (*if applicable*): _____ Customer Service Number: _____

Claims Address: _____ Policy or I.D. Number: _____

Group #: _____ Company by which Insurance is Through: _____

Primary Holder of the Insurance plan: _____ **Holder's Date of Birth:** _____ **Relation to Patient:** _____

****

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to s.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments from claims of medical malpractice. This notice pursuant Florida Law.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Laida N. Casanova, M.D.,Inc. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payer for services rendered by Dr. Laida N.Casanova. I understand that I am financially responsible to Laida N. Casanova, M.D., LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

PATIENT'S / GUARANTOR'S SIGNATURE: _____ **DATE:** _____

Laida N Casanova, LLC
11040 N. Kendall Dr., Suite C100, Miami, FL 33176
Office: 305-596-9979

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years.

Laida N Casanova, LLC
11040 N. Kendall Dr., Suite C100, Miami, FL 33176
Office: 305-596-9979

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From _____ to _____

Or

☐ All past, present, and future periods

Or

☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years.

Laïda N Casanova, LLC
11040 N. Kendall Dr., Suite C100, Miami, FL 33176
Office: 305-596-9979

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.

Notice of Privacy Acknowledgement

Laida N. Casanova, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

LAIDA N. CASANOVA, M.D., LLC

FINANCIAL POLICY

Thank you for choosing Laida N. Casanova, M.D., LLC, as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTABLES ARE DUE AT THE TIME SERVICES ARE RENDERED
WE ACCEPT CASH, VISA, MASTERCARD, AND DISCOVER

INSURANCE: We will bill your insurance company for your visits as a courtesy to you. Due to the difficulty of obtaining payment from your insurance plan, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify their medical benefits and/or limitations prior to their visit(s) and that we are a participating provider of your insurance plan. If we are not providers, are out-of-network, or a benefit is not covered, you will be responsible for any and/or all of the balance for the service(s) rendered.

HMO/REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires one for your visit. It is the Patients' responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and were required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent of the guardian accompanying the minor is responsible for any payments before service(s).

COLLECTIONS: Should your account become a collection problem, the patient/debtor assumes all costs of collection, including but not limited to the collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsible for payment of services "Not Covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.

BY SIGNING BELOW, I HAVE READ, FULLY UNDERSTAND AND ACCEPT THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH. LAIDA N. CASANOVA, M.D., LLC HAS THE RIGHT TO REFUSE PROVIDING SERVICE IF THE TERMS OF THIS CONTRACT ARE NOT ACCEPTED.

Patient /
Responsible Party Signature: _____ Date_____

Patient Name Print: _____

Kendall Oaks * 11040 N. Kendall Drive * Suite 100 * Miami * Florida * 33176
Tel: (305) 596-9979 * Fax: (305) 598-0063

Laida N. Casanova, M.D., LLC
Kendall Oaks Professional Center
11040 N Kendall Drive, Suite C-100
Miami, Florida 33176
Phone: (305) 596-9979
Fax: (305) 598-0063

MEDICAL FORM

Date: _____

NAME: _____ AGE: _____ D.O.B. _____
ADDRESS _____ PHONE: _____
OCCUPATION _____ INSURANCE _____
PLEASE CHECK ONE: SINGLE_____ MARRIED_____ WIDOW _____ DIVORCED _____
PRESENT COMPLAINTS: If you have a problem, please describe it. What is it? How long have you had it? _____

_____

HAVE YOU CONSULTED ANYONE FOR THE ABOVE? _____ DATE: _____
DR.'S NAME _____ DATE _____
REFERRED BY: _____

LAST MENSTRUAL PERIOD: _____ ***LAST PAP SMEAR*** _____

LAST MAMMOGRAM: _____ ***LAST BONE DENSITY:*** _____

PAST MEDICAL HISTORY

HYPERTENSION	YES___ NO___	CHRONIC KIDNEY DISEASE	YES___ NO___	CANCER	YES___ NO___
TUBERCULOSIS	YES___ NO___	THYROID DISEASE	YES___ NO___	EPILEPSY	YES___ NO___
HEPATITIS	YES___ NO___	DIABETES	YES___ NO___	ANEMIA	YES___ NO___
YELLOW JAUNDICE	YES___ NO___	PHLEBITIS	YES___ NO___	VENEREAL DISEASE	YES___ NO___
MIGRAINE HEADACHES	YES___ NO___	RESPIRATORY DISEASE	YES___ NO___	BLEEDING TENDENCIES	YES___ NO___

IF "**YES**" PLEASE DESCRIBE _____
IF "**OTHER**" PLEASE DESCRIBE _____
ALLERGIES _____

MEDICATIONS-List all medications you are taking (dosage and frequency)- include over the counter drugs _____

_____

HOSPITAL ADMISSIONS- List those operations and serious illness that required hospitalization (excluding pregnancy)

REASON FOR ADMISSION _____ YEAR _____
HOSPITAL _____
REASON FOR ADMISSION _____ YEAR _____
HOSPITAL _____
REASON FOR ADMISSION _____ YEAR _____
HOSPITAL _____

ANY OF THE FOLLOWING IN GRANDPARENTS, UNCLES, AUNTS, RELATIVES:

BREAST CANCER _____
DIABETES _____
UTERINE CANCER _____
RECTAL OR COLON CANCER _____
OTHER FAMILIAR DISEASES _____

OBSTETRICAL HISTORY- (Number of times)
Premature Babies_____ Miscarriages_____ Abortions_____ Living Children _____= Total Pregnancies_____

YEAR	WEEKS PREGNANCY	WEIGHT	SEX	TYPE OF DELIVERY	COMPLICATIONS

SOCIAL HISTORY SMOKING____ CIG/DAY/YR____

ALCOHOL____ OZ/WK _____

COFFEE____ CUP/DAY _____

STREET DRUGS_____ DESCRIBE _____

HISTORY OF DOMESTIC ABUSE YES____ NO____

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. **TERMINATION OF THE E-MAIL RELATIONSHIP**

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____

English Notice of Nondiscrimination

This medical practice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This medical practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This medical practice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the office administrator.

If you believe that this medical practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the office administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Nondiscrimination Taglines

Spanish / Español:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-696-6775 (TTY: 1-877-696-6775).

French Creole (Haitian Creole) / Franse kreyòl (kreyòl ayisyen)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-696-6775 (TTY: 1-877-696-6775).

Vietnamese / Tiếng Việt:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-696-6775 (TTY: 1-877-696-6775).

Portuguese / português:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-696-6775 (TTY: 1-877-696-6775).

Chinese / 中文:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-696-6775（TTY：1-877-696-6775）

French / français:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-696-6775 (ATS : 1-877-696-6775).

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-696-6775 (TTY: 1-877-696-6775).

Pelvic Health Survey

Today's Date: _____

Patient's Name: _____ 1. Age: ____ 2. Sex: □Female □Male

Bladder (check one):

3. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time

4. We would like to know how much urine <u>you think</u> leaks. How much urine do you <u>usually</u> leak (whether you wear protection or not)? Check one box.
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount

5. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 3+4+5= _____

6. When does urine leak? (Please check all that apply to you.)
   - □ Never—urine does not leak
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking? □Yes □No

Are you bothered by the number of times per day you have to empty your bladder? □Yes □No

Do you wake up at night to empty your bladder? □Yes □No

If Yes, How many times? _____

Do you feel you have to rush to the toilet to avoid an accidental leak? □Yes □No

Bowel:

1) Do you accidentally leak stool? □Yes □No
2) Do you have to strain to have bowel movements? □Yes □No
3) Do you pass gas when you do not want to? □Yes □No

Gynecological:

1) Do you experience pelvic pain? □Yes □No
2) Do/did you experience pain with intercourse? □Yes □No
3) Do you have a feeling of a "ball" in your vagina? □Yes □No
4) Hysterectomy? □Yes □No
5) Vaginal Dryness? □Yes □No
6) # of Vaginal Deliveries _____
7) # of Cesarean Sections _____

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to **Laida N Casanova, LLC** to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by **Laida N Casanova, LLC** and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that **Laida N Casanova, LLC** is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Laida N Casanova, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold **Laida N Casanova, LLC** its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold **Laida N Casanova, LLC** responsible for instances of these violations.

Signature: _____ Date: _____

Laida N. Casanova MD. LLC

Obstetrics, Gynecology, & Infertility
11040 North Kendall Drive Suite #C-100
Miami, Fl. 33176
305-596-9979 FAX: 305-598-0063

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

- a female Gynecological Exam which may include a rectal exam and a pelvic exam
- An Ultrasound Exam which may include a probe placed in the vagina.
- A rectal exam only
- An Ultrasound Exam which may include a probe placed into the rectum.
- Other procedures as listed _____
- Examination of external genitalia_____

This examination will be performed by any provider from _____ LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

_____

Date _____

HIPPA CONSENT

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, and/or Healthcare Operations.

I, _____, understand that as part of my health care, Laida N.Casanova, M.D., LLC originate and maintain papers and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. 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 a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAM

I understand and have been provided with a Notice of Information 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.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or heath care operations.

I understand that Laida N.Casanova, M.D., LLC is not required to agree to the restrictions requested.
I understand that I may revoke this consent in writing, except to the extent that the organization has already take 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 Laida N. Casanova, M.D., LLC reserve the right to change their notice practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.
Should Laida N. Casanova, M.D., change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or if I agree, email). I wish to have the following restrictions to the use or disclosure of my health information:

_____

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

[ ] I fully understand and accept or [ ] I decline the terms of this consent.

_____ _____

PRINT PATIENT'S NAME PATIENT'S SIGNATURE

DATE: _____

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____