SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.

CONSENT to the USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION for TREATMENT, PAYMENT, or HEALTHCARE OPERATIONS

I understand that as part of my healthcare, South Florida Neurology Associates, P.A. ("SFNA") originates and maintains health 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 many purposes to many other healthcare professionals and healthcare related operations.

I understand and have been provided with the opportunity to review our Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that SFNA reserves the right to change their notice and practices and prior to implementation will provide me the opportunity to review them. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that SFNA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that SFNA has already taken action in reliance thereon.

I authorize the following person(s) or class of person(s) to receive my health information:

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I request the following restrictions to the use or disclosure of my health information:

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Please use the other side of this form if more space is needed

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT
PRINT PATIENT NAME	DATE