Edwards and Cavendish, P.A.
137 West Adams Street
Jacksonville, Florida 32202

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by Edwards and Cavendish, P.A., of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices:
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (Printed):_____ Signature_____

Relationship to Patient:_____ Date:_____

Patient Authorization Form

I understand that my information is protected and not disclosed except for instances listed on the patient consent form. In order to allow another person to have access to my information, I must specifically name that person and the information I will permit disclosed. This form addresses the authorization of the release of information to another person, such as a spouse, secretary or any other that may make appointments or inquire on balances.
I hereby authorize you to use or disclose the specific information described below, only for the purposes and to the parties also described below.
Description of the specific information to be used or disclosed (Example: Account, Appointment, Health, All or None)_____. Person or entity requesting the information and authorized to make the request use or disclosure: (your name):_____
Recipient of the information (Person permitted disclosure):_____
This authorization shall remain in effect from the date signed below until (expiration date or event) _____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient And no longer be protected by HIPAA

I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research related treatment).

Patient Name (Printed):_____Signature_____Date_____