FLORIDA ORTHOPAEDIC INSTITUTE SURGERY CENTER, LLC
NOTICE OF PATIENT INFORMATION PRACTICES CONSENT FORM

I have read and fully understand Florida Orthopaedic Institute Surgery Center's *Notice of Patient Information Practices*.

- I understand that Florida Orthopaedic Institute Surgery Center may use or disclose my protected health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and administrative healthcare operations.
- I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.
- I also understand that Florida Orthopaedic Institute Surgery Center will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.
- I hereby consent to the use and disclosure of my protected health information for purposes as noted in Florida Orthopaedic Institute Surgery Center's *Notice of Patient Information Practices*.
- I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
- I understand that Florida Orthopaedic Institute Surgery Center has the right to change its *Notice of Patient Information Practices* and that I may contact this organization at any time to obtain a current copy of this Notice.

X_____

Patient/Parent/Legal Guardian's Printed Name

X_____ X_____

Signature Date