

Eduardo Diaz, MD, PA
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Miami, FL 33126
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Eduardo Diaz, MD, PA**, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO).

Eduardo Diaz, MD, PA Notice of privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy prior to signing this consent.

Eduardo Diaz, MD, PA reserves the right to revise its Notice of privacy Practices at anytime.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Eduardo Diaz, MD, PA** Privacy Officer at **5703 NW 7th ST. Miami, Fl 33126**.

With this consent, **Eduardo Diaz, MD, PA** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Eduardo Diaz, MD, PA** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **Eduardo Diaz, MD, PA** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested, but if it does, it is bound by this agreement. By signing this form, I am consenting to **Eduardo Diaz, MD, PA** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Eduardo Diaz, MD, PA** may decline to provide treatment to me.

Patient's Name
(Nombre del paciente)

Signature of Patient or Legal Guardian
(Firma del padre o guardian)

Print Name of Patient or Legal Guardian
(Nombre del padre o guardian)

Date