SIGNATURE AUTHORIZATION FOR ASSIGNED OR UNASSIGNED CLAIMS

I HEARBY AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIERS ANY INFORMATION NEEDED FOR THIS OR ANY FUTURE MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM REQUIRED TO PAY FOR ANY HEALTH INSURANCE DEDUCTIBLES, CO-INSURANCE, OR ANY OTHER CHARGES INCURRED WHICH ARE NOT PAID BY MY INSURERS OR THIRD PARTY PAYORS. THIS INCLUDES ANY COST INCURRED IN USING A COLLECTIONS SERVICE.

SIGNATURE ________________________________DATE: ____________________

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

The Patient hereby consents to the use or discloser of his/her individually identifiable health information *(Protected Health Information)* by **North Florida Sports Medicine & Orthopaedic Center,** herein after referred to as "FACILITY", in order to carry out treatment, payment, or health care operations. The Patient should review the FACILITY'S "Notice of Privacy Practices for Protected Health Information" for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing the consent form.

The FACILITY reserves for itself the right to change the terms of its "Notice of Privacy Practices for Protected Health Information" at any time. If FACILITY does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by contacting Privacy Officer, Geri Rickard, at 850-878-2549.

Patient retains the right to request that the FACILITY further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The FACILITY is not required to agree to such requested restrictions; however, if the FACILITY does agree to Patient's requested restriction(s), such restriction(s) are the binding on the FACILITY.

At all times, Patient retains the right to revoke the Consent. Such revocation must be submitted to the FACILITY in writing. The revocation shall be effective except to the extent that the FACILITY has already taken action in reliance on the Consent.

The FACILITY may refuse to treat Patient if he/she (or authorized representative) does not sign this Consent Form (except to the extent that the FACILITY is required by law to treat individuals). If Patient (or authorized representative) signs the Consent Form and then revokes Consent, the FACILITY has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the FACILITY is required by law to treat individuals).

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I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_________________________Time:____________________AM/PM

____
Signature of Patient

____
Please Print Name

____
Authorized Representative Signature*

____
Please Print Name

*Please explain Authorized Representative's Relationship to Patient and include a description of Representative's authority to act on behalf of the Patient:

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