ENDOCRINE ASSOCIATES OF FL, P.A.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may provide treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Name: ______________________ Relationship to Patient: ______________

Patient Name: ______________________________________
(PRINT NAME PLEASE)

Signature of Patient or Legal Guardian: ______________________________

______________ Date

______________________________ Witness

ENDOCRINE ASSOCIATES OF FL, P.A.
PATIENT PORTAL CONSENT FORM

By signing below, I authorize Endocrine Associates of Florida P.A. to send email communications regarding the patient portal to the email address identified below and give my expressed consent for my medical information to be made available to me using MyHealthRecord.com. I understand that I have the right to receive a completed copy of this consent.

Patient Name:____
Last Name Middle Initial First Name Date of Birth

Address:____
Street City State Zip

Please clearly print or type the email address authorized to receive the email invitation:

[ ]

Please clearly re-print or re-type the email address authorized to receive the email invitation:

[ ]

Complete the following if the email address does not belong to the patient:

Recipient:____
Last Name Middle Initial First Name

____
Relationship to the Patient

I understand that my health information is protected by federal and state law. This consent applies to records which may contain information related to testing, diagnosis or treatment for conditions and are protected by Florida Law. This consent will remain in effect unless I deactivate my account or written notice is provided to Endocrine Associates of Florida, P.A.

I understand that my username and password will be unique to my health information and sharing my username and password may grant others access to my health information. I further understand that any health information disclosed as a result of sharing my username and password may no longer be protected under federal or state law and could be further released by the individual who receives the information.

I understand that I may refuse to sign this consent and such refusal will not prohibit me from receiving treatment, payment for my treatment, enrollment in a health plan, or eligibility for benefits. I further understand that my refusal to sign this consent will not prevent me from receiving a copy of my medical records.

☐ **YES** I do wish to access my medical information and give my expressed consent for Endocrine Associates of FL, P.A. to make my medical information available to me using MyHealthRecord.com.

☐ **NO** I do not wish to access my medical information using MyHealthRecord.com.

Patient or Representative Signature:

____
Signature

____
Print Name Date

____
Relationship to Patient*

Witness Signature:

____
Signature

____
Print Name Date

*Legal authority must be verified when an individual is signing on behalf of the patient

Portal can be accessed at https://myhealthrecord.com/Portal/SSO