

Consent for Purpose of Treatment, Payment or Health Care Operations And Medical Information Release (HIPAA)

I consent to the use or disclosure of my protected health information by Liberman Advanced Surgical (FBI) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting health care operations of FBI. I understand that the diagnosis or treatment of me by FBI may be conditioned upon my consent, as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. FBI is not required to agree to the restrictions that I may request. However, if FBI agrees to a restriction that I request, the restriction is binding on FBI practice. I have the right to revoke this Consent in writing, at any time, except to the extent that FBI practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my Provider, another health care provider, a health plan, my employer, or a healthcare clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices for FBI prior to signing this document. Notice of Privacy Practices for FBI has been provided to me.

The Notice of Privacy Practices for FBI practice describes the types of uses and disclosures of my protected health information that FBI occur in my treatment, payment of my bills, or the performance of FBI health care operations.

A summary of the Notice of Privacy Practices for FBI is also posted in the waiting room.

This Notice of Privacy Practices for the FBI also describes my rights and the duties of FBI practice with respect to my protected health information.

FBI reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for FBI. I may obtain a revised Notice of Privacy Practices for FBI by contacting the office of FBI at 1890 SW Health Parkway, Suite 205, Naples. FL 34109 or by calling (239)264-7150.

Release of Medical information: If you would like us to give out Information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of Information each person may receive by checking the items we may release.

NAME	RELATIONSHIP	ALL INFO	APP ONLY	BILLING

Please list your primary care and referring physician and their Phone number and Fax number.

Referring Physician _____

Phone Number _____

Fax Number _____

Primary Car Physician _____

Phone Number _____

Fax Number _____