PATIENT CONSENT AND AUTHORIZATION FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent, I acknowledge receipt of notice of privacy practices and authorize you to use and disclose my protected health information to and inclusive of:

Disclose the patient's personal health information-treatment, billing and payment. Disclose the patient's diagnosis for related lab and diagnostic centers where treatment is rendered as requested by Tampa Neurology Associates.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Tampa Neurology Associates is not required to agree to these restrictions. However, if Tampa Neurology Associates does agree, you are then bound to comply with this restriction.

If I revoke this consent, Tampa Neurology Associates does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Tampa Neurology Associates' NOTICE OF PRIVACY PRACTICES. My signature means that I agree to allow Tampa Neurology Associates to use and disclose my personal health information to carry out treatment, payment, and health care operations.

PRINT PATIENT NAME _____

RELATIONSHIP TO PATIENT_____

SIGNATURE _____

DATE _____

THE Patient _____ (REFUSED TO SIGN A WRITTEN ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES)

EMPLOYEE SIGNATURE _____

PHYSICIAN'S SIGNATURE _____