ACKNOWLEDGEMENT OF PRIVACY PRACTICES
ON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide on what treatment is best for you and to provide that treatment. There are circumstances when we may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

Our Notice of Privacy Practices explains in detail your rights and how we can use and share your information. They are posted in our waiting room and we will furnish a copy to you upon your request. By signing this form you are acknowledging that we have made this information available to you and you agree to the terms and conditions therein.

If you do not sign this consent form agreeing to the terms our Notice of Privacy Practices, we cannot treat you. If you are concerned about some of your information, you have the right to ask us not to use it for treatment, payment, or administrative purposes. You will have to tell us specifically what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish to the extent that the law requires.

PATIENT'S ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Birth Date: _____

Maiden or other name (if applicable): _____

I acknowledge that Greater Orlando Psychiatric Associates, P.A. has made a copy of their Notice of Privacy Practices available to me effective January 1, 2006.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment, and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature (patient or authorized representative): _____

Date: _____

Relationship / authority (if signed by authorized representative): _____