G. Alexander Carden M.D David W. Dodson M.D Kleper de Almeida M.D
Internal Medicine/Infectious Disease Travelers Medical Services

1411 North Flagler Dr.
Suite 7900
West Palm Beach, Florida 33401
(561) 655-8448 Fax (561) 655-2844

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name _____

Address _____

Telephone _____

Section B: To the patient – Please read the following statements carefully.

Purpose of consent. By singing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices/ You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payments activities and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice, including and revisions of our Notice, at any time by contacting.

Contact Person: **Patricia Gallon**

Address: **1411 North Flagler Drive, Suite 7900 West Palm Beach, Florida 33401**

Telephone: **561-655-8448**

Right to Revoke. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent form will not affect any action we took in reliance to this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Signature:

I, _____, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and healthcare operations.

Signature: _____ Date: _____