# FLORIDA MEDICAL THERMOGRAPHY HIPAA CONSENT FORM

LOCATION:_____DATE_____

NAME: _____BIRTH DATE_____

ADDRESS: _____CITY_____

ST_____ZIP_____PHONE: (_____)_____

EMAIL: _____

REFERRING HEALTH CARE PROVIDER: _____

NEW THERMOGRAPHY PATIENT? YES / NO_____

NOTES:_____

_____

## Authorization to Use or Disclose Protected Health Information

**As required by the Privacy Regulations, Florida Medical Thermography may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office: **Physicians Insight, LLC**

Patient Health Information authorized to be disclosed: Thermal Images and related health history for the specific purpose of Interpretation of said images.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

*By signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement or the media.*

_____ _____

*Signature of Patient or Patient's Authorized Representative* *Date*