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**CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH  
INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND  
HEALTH CARE OPERATIONS**

As a condition of providing treatment to you, the provider may request your consent to use and disclose protected health information about you to carry out treatment, payment and health care operations.

You may revoke this consent at any time by notifying the provider *in writing*, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that the provider may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

The provider has reserved the right to change its privacy practices described in the Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and revised notice.

You have the right to request that the provider restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restriction, the provider will honor the request and it will be binding.

I hereby consent to the use and disclosure by my provider, its workforce and its business associates of my protected health information for purposes of treatment, payment and health care operations.

Signature: \_\_\_\_\_

Signature of Personal Representative of Patient: \_\_\_\_\_

Description of representative's Authority to Act on Behalf of Patient: \_\_\_\_\_

Date: \_\_\_\_\_