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135 San Lorenzo Ave.

Suite 640

Coral Gables, FL 33146

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ana M. Reyna

Tel.: (305) 648-4998 Fax:(305) 648-4993 E-mail: drhankbarreto@yahoo.com

Address: 135 San Lorenzo Ave. Suite 640, Coral Gables, FL 33146

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 will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I _____, have had full opportunity to receive, read and understand the contents of this Consent form and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 out treatment, payment activities and heath care operations. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

If this consent is signed by a legal guardian on behalf of the patient, complete the following:

Legal Guardian's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____