JAMIE WINDERBAUM FERNANDEZ, MD, PA
INTERVENTIONAL PSYCHIATRY OF TAMPA BAY

NOTICE OF PRIVACY PRACTICE

Please initial the following as recognition of an understanding.

_____ I acknowledge that I have received the clinic's *Notice of Privacy Practice* which describes the ways the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures.

_____ I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

_____ I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates to the extent permitted by law.

_____ I consent to the use and disclosure of my information for the purposes described in the clinic's *Notice of Privacy Practice*.

DISCLOSURE TO FAMILY / FRIENDS

If you wish to grant permission for the Provider to discuss your medical conditions, kindly fill out the below.

Name:	Relationship:	Date of Birth:	Contact Number:
1.			
2.			
3.			

** PATIENT/RESPRESSENTATIVE MAY REVOKE OR MODIFY THE ABOVE AUTHORIZATION IN WRITING AT ANY TIME **

COMMUNICATION ABOUT MY HEALTHCARE

Please initial/sign the following as recognition of an understanding.

_____ I agree the Provider or a representative of the Provider or an assigned staff may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

_____ I have been informed by you of your *Notice of Privacy* practices containing more complete description of the uses and disclosures of my health information.

_____ I have reviewed such Notice of Privacy practices prior to signing this consent and acknowledge a clear understanding of the Privacy Practices.

_____ I understand that Interventional Psychiatry of Tampa Bay has right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to the Protected Health Information (PHI) that has been maintained by Interventional Psychiatry of Tampa Bay. Any material changes made to this Notice will be promptly posted in the office and/or on Interventional Psychiatry of Tampa Bay website.

_____ I understand I will be given a copy of the latest version of this Notice at my next visit.

_____ I understand that I may request in writing that Interventional Psychiatry of Tampa Bay rest how private information is used or disclosed to carry out treatment and or payment, then Interventional Psychiatry of Tampa Bay may use or disclose my PHI to my health plan for payment or if pay in full for the service and items provided at the time of the visit.

_____ I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

_____ _____

PRINT PATIENT NAME DATE OF BIRTH

_____

SIGNATURE OF PATIENT

_____ _____

PRINT NAME OF PATIENT REPRESENTATIVE DATE OF BIRTH

_____ _____

SIGNATURE OF REPRESENTATIVE RELATIONSHIP TO PATIENT