NEIL A . PATTERSON, M.D., P.A.

PATIENT CONSENTS

Completion of the following sections provides consent for representatives of Neil A. Patterson, MD, PA to perform certain actions. Please review carefully.

CONSENT FOR RETRIEVING PRESCRIPTION HISTORY

I give my consent to retrieve my prescription history from external sources, such as insurance company data bases, pharmacies, etc. We use this information to improve accuracy of your prescription planning. □ ***YES*** □***NO***

CONSENT FOR REPORTING YOUR IMMUNIZATION HISTORY

I give my consent to report my immunization history to the Florida Shots program which I understand is the Florida State immunization data base. □ ***YES*** □***NO***

END OF LIFE PLANNING

Do you have End of Life Planning completed? □□**YES** □ □**NO**

If "Yes": □□ Durable Power of Attorney □□Advanced Directive □ □Living Will

Please provide a copy of your plan to scan to your chart.

If "NO", please let the staff know if you would like more information.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

By signing this form, I consent to **Neil A. Patterson, M.D., P.A.** using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this disclosure allows sharing of my PHI, which may be sensitive in nature including HIV/AIDS, sexually transmitted diseases, substance abuse, mental health conditions or pregnancy, with other physicians or medical practitioners or entities who may be involved in my care. This disclosure also allows sharing of my PHI with my health insurance company. I understand that these records may contain information from other health care providers, as well as administrative data, which may not be strictly medical in nature. I understand that once information is released to another entity **Neil A. Patterson, M.D., P.A.** is not responsible for any further disclosure by that entity. I understand that the Practice has the right to refuse to treat me ifl or my authorized representative do not sign the Consent Form at this time or choose to revoke the consent any time in the future.I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent.

Note: Requests for patient records not related to chain ofcare from outside entities, such as physicians, legal entities or non-health insurance companies, will require a separate signed authorization from the patient before information .will be released.

_____ _____

Signature of Patient or Legal Guardian _____ Date _____

A copy of this authority shall be accepted as an original