

Matthew S. Lief, M.D., P.A.
9750 N.W. 33rd Street, Suite 218
Coral Springs, FL 33065
954-755-3801
Fax: 954-755-5229

**CONSENT FOR THE USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give consent to Matthew S. Lief, M.D., P.A. and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer at 954-755-3801 or _____.

You have a right to request us to restrict how we use and disclose you protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: _____ Date: _____

Print name of patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____