Endocrine Specialists of Georgia, LLC

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Francisco Puentes, MD, FACE

Consent Form for Release of Information for Treatment, Payment and Healthcare Operations

I understand that as part of the provision of healthcare services, Endocrine Specialists of Georgia, LLC creates and maintains health records and other information describing among other things my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing consent. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except as otherwise provided by law.
- A photocopy or fax of this consent is valid as this original
- I may revoke this consent at any time, except where information has already been released, This consent is valid until revoked by me in writing.
- I have the right to request that the use of my protected health information, which is used or disclosed for the purpose of treatment, payment or healthcare operations to be restricted. Francisco Puentes, MD, Endocrine Specialists of Georgia, LLC is not bound by the restriction unless it is in agreement with the restriction.

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Printed Patient Name

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Patient Signature

_____

Date