SOUTH FLORIDA COLORECTAL INSTITUTE

ELIE SCHOCHET, M.D.

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Elie Schochet,M.D. / South Florida Colorectal Institute may use and/or disclose all of your health information in our possession (referred to as "Protected Health Information") necessary in connection with your treatment and/or obtaining payment for treatment and services that we provide for you, so that we may conduct our health care operations per the Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices Form prior to signing this consent. At times this form may be revised without notice. Carefully review the Notice of Privacy Practices form as it contains a list of rights that are available to you with respect to the use and disclosure of your protected health information including your right to request restrictions on our use and disclosure of your protected health information. You have the right to revoke this consent at any time. If you wish to revoke this consent, you must do so in writing. By signing below, you acknowledge that you have read and understand the South Florida Colorectal Institute Notice of Privacy Practices Form and authorize the release of any medical information necessary to process applicable bills to your insurance company, and request payment of benefits to South Florida Colorectal Institute.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

PHI may also be released to:

[ ] Spouse / Partner _____

[ ] Child(ren) _____

[ ] Others _____

[ ] Information is not to be released to anyone.

For future research purposes, all or part of your medical records may be reviewed by other physicians, other national health authorities (where applicable), and/or representatives of pharmaceuticals companies. Information from this study may be published in scientific journals or presented at scientific meetings. Your identity will be kept strictly confidential as stated in the section above. You can refuse to sign this consent authorization and not be part of future research studies. By signing this consent form, you give us permission to use and/or share your health information as stated above.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

21097 NE 27th Court · Suite 490 · Aventura, FL 33180
954.573.1499 · Fax 954.903.0338
www.sflcolorectal.com