KENRICK SPENCE, M.D., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient signature: ____
PRINTED NAME: ____

In connection with the medical services that I am receiving from Dr. Kenrick Spence, M.D., I hereby authorize disclosure of any and/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services:
E. Pharmacies; and
F. As otherwise required by law.

I further consent that photographs may be taken of me, or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. This consent is valid from the date executed until revoked in writing by the patient. Please understand that revocation of the consent will not affect any action we took in reliance on consent before we received your revocation and we may decline to treat or continue treating you if you revoke this consent.

I further understand that I have been given special access to the physician's privacy notice and that I have the opportunity to place special restrictions upon the consent (see below). I may request a copy of the privacy notice at any time by contacting:

Contact person: **Kitty Norwood; Office of Kenrick Spence, M.D., P.A.**
Address: **130 Hillcrest Street, Orlando FL 32801**
Telephone: **407-999-2585**

Special restrictions:____
____

YOU MAY CONTACT ME AT: ÿHOME ÿWORK ÿCELL

YOU MAY LEAVE A MESSAGE AT: ÿHOME ÿWORK ÿCELL

ADDITIONALLY, YOU HAVE MY PERMISSION TO DISCLOSE ANY OR ALL INFORMATION TO:
NAME: ______________________________ RELATIONSHIP: ____________________________
CONTACT PHONE AND ADDRESS: ____
____
NAME: ______________________________ RELATIONSHIP: ____________________________
CONTACT PHONE AND ADDRESS: ____
____
NAME: ______________________________ RELATIONSHIP: ____________________________
CONTACT PHONE AND ADDRESS: ____
____

Signed: ____
Date: ____
Personal Representative (if applicable)_____________________________
Witness: ____

For office use only:
ÿSigned form received
ÿPatient Refused
ÿEmergency
ÿLanguage barrier prevented acknowledgement or signature

Staff member's name: ____________________________ Date: __________________________