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Sareh Beladi, MD
Evlyn Brown, MD
Margaret Egan, MD
Sadiya Farooqui, DO
Urmila Mistry, MD
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Anthony Perrotti, DO
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Jupiter Medical Group

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Leonardo Bejarano, PA-C
Shay Geraghty, PA-C
Mary Huser, ARNP-C
Renee Lancaster, ARNP-C
Haley Neeley, ARNP-C
Lori O'Connor, ARNP-C
Kevin Wilkes, PA-C

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change this Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (PRINTED): _____ DATE: _____

Patient Signature: _____

Please list all relatives, friends, in which we may discuss your results with:

		Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____