Patient Consent

Patient Name: _____ **Patient Name**: _____

Patient Name: _____ **Patient Name**: _____

Patient Name: _____ **Patient Name**: _____

I hereby give my consent for **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The **Notice of Privacy Practices** provided by Dr. Mary E. Soha, MD, Inc. describes such uses and disclosures more completely.

I have the right to review the **Notice of Privacy Practices** prior to signing this consent. **Dr. Mary's Place** and or **Dr. Mary's Place, Too** reserves the right to revise its **Notice of Privacy Practices** at any time. A **Notice of Privacy Practices** may be obtained by forwarding a written request to **Dr. Mary's Place at 4051 Atlantic Blvd., Jacksonville, FL 32207**.

With this consent, **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "personal and confidential"

With this consent, **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** may email to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence I have the right to request that **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** restrict how it uses or discloses my PHI to carryout TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am consenting to allow **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Dr. Mary's Place** and/or **Dr. Mary's Place, Too** may decline to provide treatment to me.

Parent/Guardian (print): _____**Relationship to patient**: _____

Signature: _____ **Date**: _____