Advanced Specialized Laser Center™
Albert J. Nemeth, M.D.

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I hereby give my consent for Albert J. Nemeth M.D. or members of his staff to use and disclose protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO), which includes release of medical records. Albert J. Nemeth M.D.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Albert J. Nemeth M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nancy A. Nemeth, Privacy Officer, at 3165 North McMullen Booth Road, C-2, Clearwater, Florida 33761.

With this consent, Albert J. Nemeth M.D. or staff members may call my home or another alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Albert J. Nemeth M.D. or staff members may mail or e-mail to my home or another alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, or medical records. I have the right to request that Albert J. Nemeth M.D. or staff members restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions with regard to TPO disclosures.

By signing this form, I give my consent to Albert J. Nemeth M.D. or staff members the use and disclosure of 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, Albert J. Nemeth M.D. may decline to provide treatment to me.

If I am not available, or need assistance, I grant the following individuals permission to speak with Dr. Nemeth and/or Dr. Nemeth's staff regarding my care.

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Legal Guardian Print Patient's Name

_____ _____
Print Name of Legal Guardian Date

----------(Sign below when records are requested)----------

Records released to:_____ Date:_____