PATIENT PRIVACY
ACKNOWLEDGEMENT & TREATMENT CONSENT

I understand that under the Health Insurance Portability & 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 by Dr. Rosato and his staff.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Dr. Rosato has the right to change the Notice of Privacy Practices from time to time and that I may contact his office at any time by phone or in person to obtain a current copy of the Notice of Privacy Practices at:

3790 Seventh Terrace Suite 101
Vero Beach, Florida 32960
(772) 562-5859

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 healthcare 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 consent to be examined by Dr. Rosato and his staff. I understand my medical information and examination are being conducted to help diagnose and treat my complaint. My medical information will be considered confidential.

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:_____

SIGNATURE:_____

DATE:_____