VascularSpecialists
of Central Florida, Inc.

Patient: _____ Today's Date: _____

Physician: _____ Date of Birth: _____

In connection with the medical services that I am receiving from Vascular Specialists of Central Florida, Inc. ("VSCF") and its medical staff, I hereby authorize VSCF, the above-named physician, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), 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.
3. The photographs shall be used for medical records and, if, in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.
4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.
5. I also consent to the release of Protected Health Information to the following individual(s): _____

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given: _____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____

Date: _____

Witness: _____