

### **Informed Consent (Please Read and Sign)**

I hereby request and consent to the performance of medical services on me (or on the patient named below, for whom I am legally responsible) by the staff or consultants employed or contracted at the Healthcare Unity Group Inc. This includes medical services including but not limited to examination, testing, and treatment of various diseases including HIV, sexually transmitted infections, or any diseases conditions that I present for.

I understand that the results of the tests may have to be reported to the proper government agencies and by signing this agreement I agree to have my information released to any government organization.

I understand and I am informed that, as is with all healthcare procedures and treatments there are some risks including, but not limited to punctures, abrasions, cuts, infections, misdiagnoses and injuries possibly resulting in death. I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure with which the provider feels at the time, based upon the facts then known, is in my best interests.

I also understand that any information not provided to my provider cannot be taken into consideration for my healthcare needs. I understand that with any test, there is a chance for false positives and negatives as well as injury. I will hold harmless the Florida DOH and the Healthcare Unity Group Inc, its employees, contractors, and subsidiaries for any damages or injuries that I may suffer as a result of being a patient at the Healthcare Unity Group Inc.

These risks also include psychological or physical harm which can result in permanent disability, emotional loss, death or damage to personal property.

I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I have had the chance to inform the office of any or all previous medical conditions or medications that I may have been diagnosed with or prescribed and that information is accurate to the best of my ability.

I enter into this agreement freely and understand that its duration will last for as long as I am a patient of the Healthcare Unity Group Inc.

I have read, or have had read to me, the above consent. I am 18 years or older or a representative of a minor/person that has been deemed by the courts to be under my care.

This document is governed by Florida law.

If you are a minor or if you are being represented by another party please provide the appropriate person's:

## **Consent Authorization to Use or Disclose Protected Health Information**

Your authorization is requested for purposes of delivering your care in an open-door environment as described in the office's privacy notice.

In the course of your care, in this environment, routine details of your condition and care may be disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addressed and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver treatment. Your care will not be conditioned on your agreement to this authorization. You have the right not to sign this authorization and you also have the right to revoke this authorization at a later date if that is your wish. If you wish to revoke this authorization at some time in the future please advise us accordingly in writing. You always have the right to review our most updated PHI information. You can also contact our privacy officer at [AW@hugfl.org](mailto:AW@hugfl.org)

By signing this agreement, you also agree to allow Healthcare Unity Group Inc to release any and all of your information to entities it has working relationships with including pharmacies, nursing services, and third-party payers.

If you agree to this authorization and have received and reviewed our office's HIPAA privacy notice please sign and date below. A copy of this authorization will be maintained by this office.

Thank you for your cooperation and understanding.

If you are a minor or if you are being represented by another party please provide the appropriate person's: