INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III COMMUNICATIONS

I understand the Florida Department of Health (FDOH) uses a patient portal to communicate with me about my health care. In order to receive electronic communications about my health care, I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my username and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that FDOH has sent information to the portal.

_____Initial here to authorize and give expressed consent to the FDOH to make your health care information available to you through the portal.

Email Address: _____

I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

_____Initial here to remove your email address from the FDOH system and stop receiving information through the portal.

PART IV MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____	_____	_____
Client/Representative Signature	Self or Representative's Relationship to Client	Date
_____	_____	
Witness (optional)	Date	

PART VII WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature Date

_____ _____
Witness (optional) Date

Client Name: _____

ID#: _____

Original to file Copy to client DOB: _____