JOSÉ A GAUDIER M.D.P.A.
Neurology

Dr. José A.Gaudier, M.D.
Lacy Jernigan, A.R.N.P.

HIPPA Consent Form

To our patients:

Due to HIPAA regulations, we require the following information for your security:

Please list any person (family members, etc.) or the Power of Attorney that we have your permission to discuss your medical needs with, including copies of medical records, prescriptions, appointments, medical history and current concerns. If the person's name is not listed on the sheet, we will need a medical release form filled out for that person by either the patient or Power of Attorney.

Name	Relationship to patient

ABOUT OUR PRACTICE

Our office hours are Monday through Thursday from 8:00 AM to 5:00 PM and 8:00 AM to 4:30 PM on Fridays, Closed daily from 11:30 AM to 1:00 PM for lunch.

As neurologists, our practice is limited to the diagnosis and management of neurological conditions. We do not perform surgery but will refer you to a surgeon if your condition indicates. We recommend that you keep a regular follow up with your primary doctor, who could be either a family practice physician or an internal medicine physician.

Please remember that some unattended neurological conditions may result in irreversible or permanent medical consequences. It is important that you comply with your provider's recommendations. If you do not understand them, please ask for clarification. Further, it is your responsibility to reschedule any missed appointments at your earliest convenience. In addition, tests requested by our group of providers (including but not limited to a laboratory or radiological exams) are important in order to provide adequate diagnosis and monitor your health. Failure to obtain these tests or follow your provider's directions may result in delaying proper therapies leading to potentially irreversible neurological conditions.

I understand the above statement and will keep my appointment or be responsible to reschedule them at my earliest convenience, including laboratory and other testing appointments and agree to comply with my provider's recommendations. By signing this consent form, I have not waived any of my patient legal rights.

_____ _____

Patient Signature Date

An electronic or photocopy of this acknowledgement shall be valid as the original.

1740 S.E 18th Street Suite 1202, Ocala, Florida 34471 **Telephone (352) 732-8630** **Fax (352) 867-7895**