**Gowani Medical Associates, MDPA**
7224 Stone Rock Cir. Orlando Florida, 32819
Phone: 407-345-4999 Fax(407) 352-6450
Nasima Gowani, MD; Sherali Gowani, MD, FACC; Yasmeen Gowani, MD, FCCP

Once you sign Gowani Medical Associates MD PLC's consent form we may use and disclose your medical information to treat you, to obtain payment and to operate the practice.

**Examples of uses and disclosures for treatment:**
If a nurse practitioner or physician at the practice refers you for an MRI or X-Ray and needs to call the radiologist for results, the staff may give your name and the reason for ordering the Mitt to the facility.

- A Physician/Nurse practitioner may call you to advise you of treatment alternatives.

**Examples of uses and Disclosures to obtain payment:**

- The practice's billing office may submit a claim form that contains your name, address, social security number, diagnosis, and procedures performed in the office to your insurance company. In the event that your account is referred to an agency for collections all of the above including any conversation held with you will be used to gain payment.

**Examples of uses and disclosures to operate the practice:**
The practice's staff including the physician and allied health personnel may audit (read and comment upon) your chart to tract and improve our performances in assuring that we perform to provide you the highest quality of care.

- The practice's staff may leave messages on your telephones and ask you to return our call.

The Practice may use the information only with your written authorization, which can be revoked by you. The practice may use or disclose protected health information about for the other purpose without your consent if the law requires us to disclose information to government authorities examples of such uses or disclosures include suspected abuse and infectious diseases. You have following rights regarding your protected health information, and the practice must act on your request within 60 days;

- You may request restrictions at certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction.
- You may request that you receive confidential communication of protected health information.
- You may request that you inspect or copy your own protected health information.
- You may request that your information be amended.
- This is a brief summary of the notice of disclosure
- You may request a detailed paper copy of this notice.
- The law requires the practice to abide by the terms of this notice and provide individuals with notice revisions.

You may complain to the practice or to the U.S. Department of Health and Human services if you believe your privacy rights have been violated you may file a complaint with the practice by writing to Kanan Patel c/o Gowani Medical Associates MD.PLC, 7224 Stonerock Circle. Orlando, Florida 32819. No one will retaliate against you for filing a complaint.

I understand that Gowani Medical Associates MD PLC (GMA) has a detailed notice of privacy and this is just a brief summary and I can at any time request a detailed copy for my records. I further understand that GMA may need to use and/or disclose information about my health or medical problems for the purpose of arranging, conducting or consulting for my treatment, for obtaining payment for services; and for operations within the practice.

I consent to the use of my information for the purpose of treatment, payment and health care operations. I understand that my consent is not needed if the law requires GMA to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential serious bodily harm to oneself or others). I understand that I have a right to review GMA's privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operation, GMA may refuse to undertake my care.

Patient Name _____ Signature _____ Date _____