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**NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE  
HEALTH INFORMATION**

**April 14, 2003**

I acknowledge that I was provided with a copy of the Dr. Messore Notice of Privacy Practices, describing how my health information may be used or disclosed under federal law. Provided that Dr. Messore continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling (305) 273-4641, by accessing Femwell MSO website ([www.femwell.com](http://www.femwell.com)), or by requesting one at our office.

**NOTICE TO PATIENTS REGARDING YOUR DOCTORS DECISION NOT TO CARRY MEDICAL  
LIABILITY INSURANCE**

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law, subject to certain conditions, Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgement arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

**I acknowledge I am aware of the above.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name