CONSENT FORM

By signing this Consent Form, I understand that:

1. I am giving my consent for HealthSun Health Plan to use and disclose my protected health information for the following purposes and activities, as defined and explained in more detail in HealthSun Health Plan's Notice of Privacy Practices ("Notice'):

   - Treatment and Coordination of Care
   - Payment
   - Health Care Operations

2. I understand that HealthSun Health Plans Notice provides more complete information about how HealthSun Health Plans uses and discloses protected health information about me. I understand that I have a right to review the Notice before signing this consent form. I understand that HealthSun Health Plan encourages me to read, understand and ask questions about the Notice, prior to signing so that I may better understand HealthSun Health Plan's privacy practices.

3. As explained in the Notice, I understand that the terms of HealthSun Health Plans Privacy Notice may change. If HealthSun Health Plan changes the terms of its Notice, I understand that I may obtain a revised copy of the Notice by writing to HealthSun Health Plans at the following address:

   HealthSun Health Plans
   1205 SW 37th Avenue 2nd Floor
   Miami, Florida 33135

4. I understand that I have at the right to request that HealthSun Health Plans restrict how protected health information about a me is used or disclosed for treatment, coordination of care, payment or healthcare operations. I understand that HealthSun Health Plans is not required to agree to my requested restrictions. I understand if they do agree to my request that they will be bound by their agreement.

5. I understand that I may revoke this Consent Form at any time by notifying HealthSun Health Plans in writing at the address stated above of my intent to revoke this Consent Form, except that if I do notify HealthSun Health Plans in writing of my intent to revoke this Consent Form, such revocation will not have any effect on any information used or disclosed by HealthSun Health Plans for treatment, payment, coordination of care, or health care operations before the revocation is received.

Signature of Member or Representative	Date
Social Security Number	Date of Birth

Printed Name of Member or Member's Representative

Relationship of Representative given legal authority to act for Member

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