

SID DANESH, M.D.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, the office of Sid Danesh, MD (office) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Sid Danesh's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office's Privacy Officer at 316 E. Las Tunas Dr. Suite 103, San Gabriel, CA 91776.

With my consent, the office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as they are marked Personal and Confidential.

With my consent, the office may fax or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting the office's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don't sign this consent, Sid Danesh, MD may decline to provide treatment to me.

I have read the Notice of Privacy Practices prior to signing this consent

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian