PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review and receive a copy of our notice before signing the Consent. The terms of our Notice may change and if we do so, you may obtain a revised copy by contacting our office.

With my consent, Elizabeth R. Reyes, M.D., and staff may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our office's Notice of Privacy Practices for a more complete description of such used and disclosures.

With my consent, Elizabeth Reyes, M.D. and staff 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, but not limited to laboratory results.

With my consent, Elizabeth R. Reyes, M.D., and staff may email or mail to my home or other designated location that assist the practice in carrying out TPO such as appointment reminders cards, patient statements, and advertisements for our services.

I have the right to request that Elizabeth R. Reyes, M.D., and staff restrict how it used or disclosed 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 to by agreement.

By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your former Consent.

If I do not sign this Consent, Elizabeth R. Reyes, M.D. and staff may decline to provide treatment to me. The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and I have had the opportunity to review this notice.
- The practice reserves the right to change The Notice of Privacy Practices at any time.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke the Consent at any time in writing with a verifiable signature on file, at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

_____ _____

Signature of patient or legal guardian Date

_____

Print Name Relation to patient witnessed by:

_____ _____

Print Name of Guardian Practice Representative