Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, Gagan J. Singh, M.D., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment;
2. A means of communication among the many health professionals who contribute to my care;
3. A source of information for applying my diagnosis and surgical information to my bill; and
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided the opportunity to view the Notice of Privacy practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address that I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to see and obtain copies of my medical record, I understand that I have the right to request amendments to be made to my medical record. I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of written request, and I understand that I may have to pay a reasonable charge of $0.20 per page for any copies after the first request in a 12 month period. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice as already taken action in reliance thereon.

IF YOU HAVE RESTRICTIONS, PLEASE NOTE THEM BELOW. IF NO RESTRICTIONS, PLEASE WRITE NONE.

✦ I request the following restrictions be made to the use or disclosure of my health information:

_____

✦ I request restrictions be made to the use or disclosure of my health information to certain people:

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **Date**

x _____ _____