Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name:

I hereby consent to the use or disclosure of my protected health information by the practice of Dr Charles W Perry hereinafter referred to as "Dr. Perry" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Perry may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding to the practice and Dr. Perry.
I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Perry or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr Charles W Perry another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 3800 J Street Suite 210, Sacramento CA 95819.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient

_____ _____

Description of Personal Representative's Authority Date

Patient Initials: _____