

DDR

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Dixie Richards office may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Dixie Richards 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 the consent. Dr. Dixie Richards office reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained a by forwarding a written request to Dr. Dixie Richards Privacy Officer at 11633 San Vicente Blvd. Suite 310, Los Angeles, CA., 90049.

With my consent, Dr. Dixie Richards 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, Dr. Dixie Richards 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 long as they are marked Personal and Confidential.

By signing this form, I am consenting to Dr. Dixie Richards office 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 do not sign this consent, Dr. Dixie Richards Practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's name

Date

Print Name of Patient or Legal Guardian