CONSENT TO THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

With my consent, Dr Dugue/ Dr Tarr (hereafter referred to as "Provider") may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Provider's Notice of Privacy Practices for more complete uses and disclosures.

I _____ have been provided a copy of the document entitled Notice of Privacy Practices which provides a complete description of potential uses and disclosures of my protected health information.

I have had the right to review the Notice of Privacy Practices prior to signing this consent. The Provider's 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 Privacy Officer, 25982 Pala, Suite 270, Mission Viejo, CA 92691.

The Provider's office may call me or other designated locations 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.

The Provider's office may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements

I understand that I have the right to request that Dr Dugue/ Dr Tarr restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operation. I further understand that the Provider is not required to grant any request to restrict the use or disclosure of information. If, however, the Provider agrees to a requested restriction, the restriction is binding on the Provider.

By signing this form, I am consenting to Dr Dugue's / Dr Tarr's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Provider has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Dugue/ Dr Tarr may decline to provide treatment to me.

_____
Patient's Name (printed)

_____ _____
Signature of Patient or Legal Guardian Date