

Effective Date: 4-1-11

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

With my consent, Noel TD Chiu, M.D., a.m.c. may use and disclose protected health information (PHI) about me, in order to carry out treatment, payment, and health care operations (Treatment, Payment, and Health Care Operations= TPO). For example: We give your health plan the information it requires before it will pay us. Please refer to Noel TD Chiu, M.D., a.m.c. 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 this consent. Noel TD Chiu, M.D., a.m.c. reserves the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Office Manager, Privacy Officer, at 3701 Lone Tree Way, Suite 6, Antioch, CA 94509.

With my consent, Noel TD Chiu, M.D., a.m.c., may call my home or other designated location, and leave a message on voice mail or in person, in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, as well as other results.

With my consent, Noel TD Chiu, M.D., a.m.c. may mail to my home or other designated location any item that assists the practice in carrying out TPO, such as appointment reminder cards, patient result cards, and patient statements. I have the right to request that Noel TD Chiu, M.D., a.m.c. restrict how he uses or discloses 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 by this agreement.

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed above. You will not be retaliated upon for filing a complaint.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

REGION IX, Office for Civil Rights, U.S. Department of Health and Human Services

90 7th Street, Suite 4-100

San Francisco, CA 94103

(415) 437-8310; (415) 437-8311 (TDD); (415) 437-8329 Fax

OCRMail@hhs.gov

The complaint form may be found at: www.hhs.gov/ocr/privacy/hippa/complaints/hipcomplaint.pdf.
You will not be penalized for filing a complaint.

By signing this form, I am consenting to Noel TD Chiu, M.D., a.m.c. 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 with my prior consent. If I do not sign this consent Noel TD Chiu, M.D., a.m.c. may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Patient's Name	Date

Printed Name of Patient or Legal Guardian

Please list below if you would like to add anyone, ie: spouse, partner, parent, whom we can release your medical information to:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
DOB: _____	DOB: _____

I understand that it is my responsibility to notify Diablo Dermatology should any of the above information change.

_____	_____
Patient, Parent/Guardian Signature	Date