

## Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Ram Mudiyam, MD, Inc., may use and disclosed protected health information about you to carry out treatment, payment and health care operations. Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review the Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office at 11190 Warner Avenue, Suite 310, Fountain Valley, CA 92708.

With your consent, Ram Mudiyam, MD, Inc., may call your home or office to leave a message in reference to any items that assist the practice in carrying out treatment, payment and health care operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Ram Mudiyam, MD, Inc., may mail to your home or office any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of treatment, payment or health care operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve Ram Mudiyam, MD, Inc., of all liability.

You have the right to request that we restrict how we use or disclose your protected health information to carry out treatment, payment, and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or LegalGuardian \_\_\_\_\_ Date \_\_\_\_\_  
This Authorization Will Remain Standing Until Revoked in Writing.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Print Name of Patient or Legal Guardian \_\_\_\_\_ Date of Birth \_\_\_\_\_

### ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, \_\_\_\_\_, decline to the use and disclosure of my PHI to carry out treatment, payment and health care operations.