Jean-Claude Hage, M.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Jean-Claude Hage, M.D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I also acknowledge that The Notice of Privacy Practices which describes such uses and disclosures more completely has been provided by **Jean-Claude Hage, M.D.** for my review.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Jean-Claude Hage, M.D.** reserves the right to revise The Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Jean-Claude Hage, M.D. 399 E. Highland Ave, #222 San Bernardino, CA 92404**.

With this consent, **Jean-Claude Hage, M.D.** may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Jean-Claude Hage, M.D.** may mail to my home or other alternative 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."

With this consent, **Jean-Claude Hage, M.D.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Jean-Claude Hage, M.D.** restrict how my PHI is used or disclosed to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Jean-Claude Hage, M.D.** to use and disclose my PHI to carry out TPO. I am also acknowledging that The Notice of Privacy Practices has been provided for my review.

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, or later revoke it, **Jean-Claude Hage, M.D.** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient's Name Date

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Print Name of Patient or Legal Guardian, if applicable