CUREtology Surgical Oncology

Medical Corporation & Associates

1513 South Grand Avenue, Suite 400
Los Angeles, CA 90015
Appointments: 213.742.6400
Www.CUREtology.com

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for **CUREtology Surgical Oncology & Associates** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **CUREtology Surgical Oncology & Associates** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **CUREtology Surgical Oncology & Associates** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **CUREtology Surgical Oncology & Associates 1513 South Grand Avenue, Suite 400 Los Angeles, CA 90015.**

With this consent, **CUREtology Surgical Oncology & Associates** 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, **CUREtology Surgical Oncology & Associates** 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, **CUREtology Surgical Oncology & Associates** 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 **CUREtology Surgical Oncology & Associates** restrict how it uses or discloses my PHI 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 **CUREtology Surgical Oncology & Associates** to use and disclose 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, or later revoke it, **CUREtology Surgical Oncology & Associates** may decline to provide treatment to me.

Note: *Laws for the state of California prevail.*

CONFIRMATION OF REVIEW AND RECEIPT

By signing below, I acknowledge that I have reviewed this document and received a copy upon request. DO NOT SIGN this document without a review.

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Revised 10/31/2017