CONSENT

As our patient, we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this MUST be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which, relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

_____ _____

Signature (Patient or Parent/Guardian if patient under 18) Date

MEDICAL INFORMATION RELEASE & ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature (Patient or Parent/Guardian if patient under 18) Date

I hereby authorize Dr. Albert C. Chan to apply for benefits on my behalf for covered services rendered by him by his order. I request that payment from my insurance company be made directly to Dr. Albert C. Chan or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ _____

Signature (Patient or Parent/Guardian if patient under 18) Date