MANJARI ARAVAMUTHAN, MD
INTERNAL MEDICINE & PRIMARY CARE

200 JOSE FIGUERES AVE # 230
SAN JOSE, CA 95116
TEL: (408) 929-6922

1569 LEXANN AVE # 220
SAN JOSE, CA 95121
TEL: (408) 929-6922

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the following is offered for your information and consent. Please be aware that it is the office's policy to require your reading and signing this consent prior to the provision of the treatment or any other medical services. If you have any questions, you may contact this office and speak with Dr. Aravamuthan or her staff.

I _____, current reside at _____

in (city) _____, _____ County, CA. do hereby consent the use and disclose of my individually identifiable health information("Health Information") by Dr. Aravamuthan for the purpose of providing treatment to me, receiving engaging in health care operations, such as office management, credentialing case management and quality management.

I understand that 'Notice Of Member's Privacy Rights'("Notice") describes in more detail the types of uses of disclosures of Protected Health Information involved in treatment, payment, or health care operations, and that I have received a copy of this Notice prior to signing this consent. I understand that if I choose not sign this consent, this provider may withhold medical services other than emergency services.

I understand that if I sign this consent, I still have the right to request a restriction on Provider's use or disclosure of any and /or all Personal Health Information to any and / or all locations, entities or persons. I further understand that provider is not obligated to agree to my request . However, if Provider does not agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, writing, at any time, except to the extent that Provider has already relied on this consent, and that any revocation will become effective on that date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

_____ (Signature)

_____ (Date)