

Poneh Rahimi, MD

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Patient Consent for Disclosure and Use of Protected Health Information

I am aware that Poneh Rahimi, MD is licensed and regulated by the Medical Board of California (www.mbc.ca.gov 800-633-2322).

I hereby give my consent for Poneh Rahimi, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The notice of Privacy Practices provided by Poneh Rahimi, MD describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Poneh Rahimi, MD 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 the receptionist. By signing this form, I am consenting to allow Poneh Rahimi, MD to use and disclose my PHI to carry out TPO, as mentioned above, and I understand that I may revoke my consent in writing, except to the extent that the practice has already made a disclosure based upon my prior consent. If I do not sign this consent, or later revoke it, Poneh Rahimi, MD may decline to treat me.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

(FILL OUT ALL THAT APPLY.)

VERBAL COMMUNICATION:

Home Phone#: _____ OK to leave messages? Y/N

Work Phone#: _____ OK to leave messages? Y/N

Cell Phone#: _____ OK to leave messages? Y/N

WRITTEN COMMUNICATION:

OK to mail to home address (the address given on patient information sheet)? Y/N

Signature

Print Name