

# KANER MEDICAL GROUP, P.A.

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Kaner Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

With this consent, Kaner Medical Group 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, Kaner Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as patient statements.

With this consent, Kaner Medical Group 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 Kaner Medical Group 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 Kaner Medical Group 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, Kaner Medical Group may decline to provide treatment to me.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Date

\_\_\_\_\_  
Print Patient's Name      Relationship to Patient

\_\_\_\_\_  
Print Name of Legal Guardian, if applicable