Zahir Yousaf, MD, FCCP

PULMONARY AND SLEEP MEDICINE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND DESIGNATION OF PERSONAL REPRESENTATIVE

With your consent, we may use and disclose protected health information (PHI) about you to carry out **t**reatment, **p**ayment, and **h**ealth care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, we may call your home, office, or other alternative location and leave a message or voicemail message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to your clinical care.

With your consent we may mail to your home, office, or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With this consent, we may e-mail to your home, office, or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment, and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. **If you decline to sign this consent, or later revoke it, we may decline to provide treatment for you.**

_____ _____

Signed (Patient or representative) Patient's date of birth

_____ _____

Printed Name Date

****

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, _____ (print name), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This person may receive information regarding my health care treatment as described above.

_____ _____

Print name of personal representative Patient Signature