Sean Kossari, M.D., Inc.

Obstetrics, Gynecology & Infertility

14901 Rinaldi Street, Suite 320 Mission Hills, Ca 91345 Tel: (818)365-1616 Fax: (818)365-1811

HIPPA
PATIENT CONSENT FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS SUMMARY CAREFULLY.

1. OUR LEGAL DUTY:

We are required by law to protect the privacy of your health information, provide a notice concerning our privacy practice, follow the privacy practice that we describe in our Notice of Privacy, and seek your acknowledgement of receipt of this notice. Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you and how you can get access to this information. Our notice contains a Patient's Right Section describing your rights under law. You have the right review and request and copy of our notice of privacy practices before signing this consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

2. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

By signing this form you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. For example, your health information may be shared with other providers to whom you are referred. You have the right to revoke this consent by requesting that in writing. However, such revocation shall not affect any disclosure we have already made in reliance upon your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

3. YOUR RIGHT:

You have the right to look at or get a copy of your information. If you request a copy, we mazy charge you a fee. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor the agreement. You also have the right to request a list of the types of disclosure of your information that we have made. You may also request that we correct the information or add any missing information.

4. THE PATIENT UNDERSTANDING THAT:

If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with the decision we have made about access to your health information, you may contact our Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

THE PATIENT UNDERSTANDING THAT:

1. Protect health information may be disclosed or used for treatment, payment, or health care operations.
2. Our Practice has a Notice of Privacy Practices and that you the patient have the opportunity to review this notice.
3. The Practice reserves the right to change this notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the practice does not have to agree these restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition receipt of treatment upon the execution of this consent.
7. If you have questions or complaints, please contact our privacy officer.

PRINT PATIENT NAME:___________________________________

PATIENT SIGNATURE:_____________________________ DATE:_______________