Thakkar, Patel, Avalos MD's LLC

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HIPPA CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, ________________________________, DOB:__________________ hereby authorize **Thakkar, Patel, Avalos MD's LLC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent,**Thakkar, Patel, Avalos MD's LLC** can refuse to treat me.

I have been informed that, **Thakkar, Patel, Avalos MD's LLC** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying**Thakkar, Patel, Avalos MD's LLC** in writing, but if I revoke my consent, such revocation will not affect any actions that**Thakkar, Patel, Avalos MD's LLC** took before receiving my revocation.

I understand that **Thakkar, Patel, Avalos MD's LLC** has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Thakkar, Patel, Avalos MD's LLC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Thakkar, Patel, Avalos MD's LLC** does not have to agree to such restrictions, but that once such restrictions are agreed to, must adhere to such restrictions.

I hereby agree that the following physicians may have access to my records:

Primary Physician:____

Referring Physician:____

Additional Physicians:____

I hereby agree that these friends/family members may have access to my medical information:

1.____ Relationship:______________

Method: Face to Face Telephone Written E-mail

2.____ Relationship:______________

Method: Face to Face Telephone Written E-mail

3.____ Relationship:______________

Method: Face to Face Telephone Written E-mail

Patient or Authorized persons signature: ______________________________ Date:__________