



**Patient Consent For Use and Disclosure
of Protected Health Information**

I hereby give my consent to Dr. Debora Sedaghat, D.O., for the use and disclosure of protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please, note that Dr. Debora Sedaghat, D.O.. Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Debora Sedaghat, D.O., reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Debora Sedaghat, D.O..

With this consent, an office staff of Dr. Debora Sedaghat, D.O., may call my home or other alternative locations 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 appointments reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Also, with this consent, a form of mail will be sent to my home or other alternative locations. Any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Dr. Debora Sedaghat, D.O., may e-mail to my home or other alternative location any items that assist the practice in carrying and TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Debora Sedaghat, D.O., restrict how it use or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if so, it so bound by this agreement. By signing this form, I am consenting to Dr. Debora Sedaghat, D.O., the use and discourse of my PHI to carry out TOP.

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.

Dr. Debora Sedaghat, D.O., may decline to provide treatment to me.

Patient Signature or Legal Guardian

Date

Print Patient Name