HIPAA CONSENT FORM

Chino Hills Family Medical Group

Patient Consent for Use and Disclosure of Protected Health Information

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

(The Notice of Privacy Practices provided by **Chino Hills Family Medical Group** describes such uses and disclosures more completely). I have the right to review the Notices of Privacy Practices prior to signing this consent. **Chino Hills Family Medical Group** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Chino Hills Family Medical Group
Attn: Privacy Officer
15631 Central Ave
Chino, Ca 91710

With this consent, **Chino Hills Family Medical Group** may call my home or alternative location and leave a message or voice mail or in person referencing any items that assist the practice in carrying out **TPO**. With this consent, **Chino hills Family Medical Group** may mail or email to my home or alternate location any items that assist the practice in carrying out TPO.

I have the right to request that **Chino Hills Family Medical Group** restrict how it uses or discloses my **PHI** to carry out **TPO.** This practice is required to agree to my requested restrictions and is bound by this agreement.

_____**(Initial)** With this consent, **Chino Hills Family Medical Group** may access my prescription history through medical insurance claims to verify medication names, dosing and quantities to carry out **TPO.**

I allow **Chino Hills Family Medical Group** to release my specifically listed **PHI to**

_____
Name and Relationship of person(s) authorized to receive my PHI

The person(s) named above is/are **ONLY** authorized to inquire and receive PHI, pertaining to the following:

- ☐ ALL PHI
- ☐ Other: _____
  (Specify)

This consent expires on: _____
(List specific date or write" Does Not Expire")

By signing this form, I am consenting to allow **Chino Hills Family 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, **Chino Hills Family Medical** may decline to provide treatment to me.

_____
Signature of Patient/Parent/Legal Guardian

_____ Date _____
Print Name of Patient or Legal Guardian

Revised 12/5/2017