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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please refer to "Notice of Privacy Practices" Brochure, refer to the "Request Restrictions" section.

I request the following restrictions to the use or disclosure of my health information:

<p>Medical Information can be discussed with</p> <p><input type="checkbox"/> Patient only</p> <p><input type="checkbox"/> Family member or friend _____</p> <p><input type="checkbox"/> Physician</p> <p><input type="checkbox"/> Other _____</p>	<p>Detailed messages regarding test results can be left on answering machine</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Phone Number _____</p>
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OTHER RESTRICTIONS _____

PATIENT:

Signature of Patient or Legal Representative Date Witness Signature

OFFICE USE ONLY:

Accepted _____

Denied Signature Title Date