

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information by Dr. Chung-En Huang for the purpose of diagnosing or providing treatment to me, prescribing medications through a pharmacy or pharmaceutical company, obtaining payment for my health care bills or to conduct healthcare operations of C.E. Huang, M.D. I understand that diagnosis or treatment of me by Dr. Huang may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr Huang is not required to agree to the restrictions that I may request. However, if C.E. Huang agrees to the restrictions that I request, the restriction is binding on C.E. Huang.

I have the right to revoke this consent, in writing, at any time, except to the extent that C. E. Huang, M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review C.E. Huang, M.D.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the office of Dr. Huang. The Notice of Privacy Practices for C.E. Huang, M.D. is also provided in the office waiting room where it is posted on the wall. This Notice of Privacy Practices also describes my rights and C.E. Huang, M.D. duties with respect to my protected health information.

C.E. Huang, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Dr. Huang and requesting a revised copy to be sent in the mail or asking at the time of my next appointment.

X _____

Signature of Patient or Personal Representative

**"By signing this document, I am stating I have read
the Notice of Privacy Practices for this office"**

Print Name of Patient or Personal Representative

Date

Description of Personal Representative Authority

Texas State Law requires us to get your permission to release any medical information regarding your care, to anyone other than yourself or your medical insurance company. Please list below persons who you authorize us to release your medical information to:

1) _____
Name Relationship

2) _____
Name Relationship

