Patient Privacy Practices, Notice, and Consent Form

The patient understands that he/she has certain rights to privacy regarding his/her own protected health information. These rights are given to the patient under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that by signing this consent he/she authorizes Ata Moshyedi, M.D., Radman Mostaghim, M.D. and their associates to use and disclose patient's protected health information to:

- Carry out treatment (describe treatment);
- Share clinical information with other health care providers involved in the patient's care;
- Obtain payment from third party payers (e.g. insurance companies);
- Carry out the day-to-day health care operations of the practice.

The patient has also been informed of, and given the right to review a copy of the Statement of Privacy Practices, which contains a more complete description of the uses and disclosures of protected health information and patient rights under HIPAA.

The patient understands that Ata Moshyedi, M.D., Radman Mostaghim, M.D., and their associates reserve the right to change the terms of this notice from time to time and that the patient has the right to contact the office at any time to obtain the most current copy of this notice.

Finally, the patient understands that he/she may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date of revocation shall not be affected. If the patient does not sign this consent at this time, or revokes it at any later date, Ata Moshyedi, M.D., Radman Mostaghim, M.D., and their associates may decline to provide treatment to the patient.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____