Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
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occhildneurology.com

Patient Name:	Date of Birth:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Melissa Przeklasa Auth, M.D. 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 Melissa Przeklasa Auth, M.D. describes such uses and disclosures more completely.)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area, and that a copy of any amended Notice of Privacy Practices is also available on this medical practice's website.

Melissa Przeklasa Auth, M.D. 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: Office Manager; 30131 Town Center Drive # 237; Laguna Niguel, CA 92677; (949) 495 - 6100.

With this consent, Melissa Przeklasa Auth, M.D. may call, mail or email my home or other alternative location (including leaving a message on voice mail) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Melissa Przeklasa Auth, M.D. may use my PHI for continuity and coordination of my treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Our office may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

I have the right to request that Melissa Przeklasa Auth, M.D. restrict how she uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Melissa Przeklasa Auth, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing 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, Melissa Przeklasa Auth, M.D. may decline to provide treatment to me.

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Signature of Legal Guardian Date

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Print Name of Legal Guardian Date