

SUGANTHI RAVINDRAN M.D P.C

PATIENT CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Suganthi Ravindran Physician P.C may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy practices prior to signing this consent. Suganthi Ravindran M.D P.C reserves the right to revise its Notice of Privacy at any time. .

With my consent, Suganthi Ravindran M.D P.C may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and radiology results, among others. Normal lab values and non-sensitive information may be left with immediate family members or on your voicemail. However, we will make every attempt to discuss abnormal results and non-sensitive information only with you, the patient. As Always, you are welcome to contact us at any time in reference to any aspect of your care. With my consent, Suganthi Ravindran M.D P.C may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and sympathy cards may be sent, however, without being marked personal and confidential.

With my consent, Suganthi Ravindran M.D P.C may e-mail to my home or other designated location with any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Suganthi Ravindran M.D P.C restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restriction, but if it does it is bound by this agreement.

By signing this form, I am consenting to Suganthi Ravindran M.D P.C use and disclosure of my PHI to carry out TPO.

Disclosures in reliance upon my prior consent. If I do not agree to this consent, Suganthi Ravindran M.D P.C may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print name of patient

I allow this person to pick up or call about records on my behalf.

Print name of person allowed to pick up records

Signature of patient