

**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations
&
Acknowledgement of Receipt of Notice of Privacy Practices**

I understand that as part of my health care, M.SHAMALA, M.D., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been presented with a copy of M.Shamala, M.D.'s Notice of Privacy Practices (hereto forth referred to as "the Notice"), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that M.Shamala, M.D., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that M.Shamala, M.D., reserves the right to change the Notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should M.Shamala, M.D., change the Notice substantively, she will send a copy of any revised Notice to the address I've provided, whether by U.S. mail or email.

I request the following restriction(s) concerning the use or disclosure of my personal medical information:

LOS GATOS MEDICAL GROUP
Family Medicine & Urgent care
M.SHAMALA, MD
FAMILY PRACTICE

555 Knowles Drive, Ste # 200
Los Gatos, CA 95032
Tel: 408. 370 0200
Fax: 408.320 0202

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. Further, I permit a copy of this authorization to be used in place of the original

Signature of patient
or parent/guardian if minor

Print Name

Date

If not signed by patient, please indicate relationship to patient (e.g., spouse):

Relationship: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of the Notice, please document the date and time the Notice was presented to patient and sign below.

Presented on (date and time): _____