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

555 Knowles Drive, Ste # 109
Los Gatos, CA 95032
Tel: 408. 370 0200
Fax: 408.320 0202

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 # 109
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: ________________________________

HIPAA Addendum for eEHX

We may also share protected health information with your other healthcare providers in order for him or her to treat you. This information is shared electronically, in a restricted, secure format.

You may request that this office not provide electronic access to your protected health information to other healthcare providers. Opting out will stop this office from sharing your health information electronically with all other healthcare providers. However, this will not stop your other doctors and healthcare providers from electronically sharing your health information. Note that if you stop this office from electronically sharing your protected health information, it may not be available, even in an emergency. Denying this access to your healthcare providers may make it more difficult for doctors and healthcare providers to coordinate your care. This could have an adverse effect on the quality and efficiency of your healthcare services.

If you do Opt Out, we may share your health information with other healthcare providers for the purposes of your treatment, and to coordinate your care.

____________________	____________________	_______________
Signature of patient or parent/guardian if minor	Print Name	Date

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): ____________________