HANH N. HOANG, MD
Obstetrics & Gynecology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Hanh Hoang 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 at www.hanhhoangmd.com describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Hanh Hoang reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 210 N. Jackson Ave, Ste 10, San Jose, CA 95116.

I have the right to request that Dr. Hanh Hoang 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.

With this consent, Dr. Hanh Hoang and associates may call my home or other alternative location 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 test results, among others.

With this consent, Dr. Hanh Hoang and associates may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Dr. Hanh Hoang and associates may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I may revoke my consent in writing except 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, Dr. Hanh Hoang may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

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Name of Patient (Please print)

_____ _____

Name of Legal Guardian, if applicable (Please print) Relationship to Patient