## Patient Consent for Use & Disclosure of Protected Health Information

With my consent, Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at 23600 Telo Avenue Suite 180, Torrance, CA 90505.

With my consent, Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano may call my home or other designated 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 appointments, insurance items and any call pertaining to my clinical care.

With my consent, Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano my mail to my home or other designated location any items that assist the practice in carrying out TPO, such as surgery letters and patient statements.

However, 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 Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano the use and disclosure of my PHI to carry out TPO.

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, Drs. Lorman, Striplin, Peck, Turek, Purne, Rogers, Ahn, Zickuhr and Mellano may decline to provide treatment to me.

**I hereby consent to the release of PHI to the following individuals. I understand this authorization will be in effect until which time it is revoked.**

| Name | Relationship |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____

Signature of Patient or Parent/Legal Guardian

_____

Patient's Name Date