Leslie M. Brocchini, MD
Wellness Integrative MedicineCosmetics
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209-288-2293

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Leslie M. Brocchini, MD** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Leslie M. Brocchini, MD**'s Notice of Privacy Practices for a more compete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Leslie M. Brocchini, MD** reserves the right to revise it Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Leslie M. Brocchini, MD**'s Privacy Officer.

With my consent, the office 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 appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office 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 patient statements as long as they are marked Personal and Confidential.

With my consent, the office may e-mail to my home or other designated location ay items that assist the practice in carrying out TPO, such as appointment reminder cards and practice statements. I have the right to request that the office restrict how it uses or discloses my PHI to carry out TPO. 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 **Leslie M. Brocchini, MD**'s 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, **Leslie M. Brocchini, MD** may decline to provide treatment to me.

Signature:_____ **Date:**_____

Printed Name:_____