Laurie B. Reynard, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Laurie B. Reynard, M.D., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Reynard's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review Dr. Reynard's Notice of Privacy Practices prior to signing this consent. Laurie B. Reynard, M.D. reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a signed written request to Laurie B. Reynard, M.D.'s Privacy Officer at 2021 Santa Monica Boulevard, Suite 730E, Santa Monica, California 90404.

With my consent, Laurie B. Reynard, M.D. may call my home or other designated location and may send faxes, email communication, and leave messages at my home or other designated location. With my consent, Laurie B. Reynard, M.D. may leave a message on voice mail, email, or in person, in reference to my items that assist in the practice of carrying out TPO, such as appointment reminders, insurance items, and any communication pertaining to my clinical care, including laboratory results among others. With my consent, Laurie B. Reynard, M.D. may email or mail to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment confirmations, appointment reminders, and patient statements.

I have the right to request that Laurie B. Reynard, M.D. restrict how it uses 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 Dr. Reynard's use and disclosure of my PHI to carry out TPO. My signature also acknowledges that I have had an opportunity to review Dr. Reynard's Notice of Privacy Practices. 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 don't sign this consent, Dr. Reynard may decline to provide treatment to me.

Signature of Patient or Legal Guardian: _____

Patient Name: _____

Print Name of Patient or Legal Guardian: _____

Date:_____