CONSENT FOR PURPOSE OF TREATMENT. PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by YBPC Medical Inc, herein known as "Health Care Provider" for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of "Health Care Provider."

I understand that diagnosing or treatment of my "Health Care Provider" may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. "Health Care Provider" is not required if I agree to the restrictions that I may request. However, if "Health Care Provider" agrees to a restriction that I request, the restriction is binding on "Health Care Provider" and Health Care Provider's Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the "Health Care Provider" has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me or there is reasonable basis to believe the information may identify me.

I understand I have a right to review "Health Care Provider" (s) Notices of Privacy Practices prior to signing this document that the "Health Care Provider" has provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of "Health Care Provider." The Notice of Privacy Practices for "Health Care Provider" is also provided at 1750 Huntington Dr. Suite B, Duarte, CA 91010. This notice of Privacy Practices also describes my right s and the duties of "Health Care Provider" with respect to my protected health information.

"Health Care Provider" reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy by assessing the "Health Care Provider's" office and requesting a revised copy be sent in the mail or asking for one at time of my next appointment.

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize YBPC Medical Inc. to use and disclose the health and medical information of signed patient for the purposes of treatment, payment and Health Care Operations.

Treatment (includes activities performed by health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.)

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.)

Health Care Operations (includes the necessary administrative and business functions of our office.)

You may review "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent. Please verify that you have received a copy of our Notice by placing your initial here._____

Because we reserve the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the Notice will be posted in office indicating the effective date of the Notice in the upper right hand corner. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the Notice describing how medical information about you may be used and disclosed and how you can access this information.

We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purpose without your consent or authorization.

As our patient, you have important right relating to inspecting and copying you r medical information that we maintain, amending or correcting that information, obtaining and according to our disclosures of your medical and disclosures of your medical information, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect. You have the right to receive a copy of your most current Notice in effect. You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and one will be provided.

Date: _____

_____ S.S.#_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority