JAMES D. WETHE, MD – American Board of Plastic Surgery
3440 Lomita Boulevard, Suite 220 Torrance, CA 90505

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review and receive a copy of our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

With my consent, James D. Wethe, MD may use and disclose protected health information (PHI) about me to carry out ***Treatment, Payment*** *and healthcare* ***Operations*** *(TPO).* Please refer to our office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, James D. Wethe, MD and staff may call my home or other designated location (please specify) _____ *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 issues and any call pertaining to my clinical care.*

I have the right to request James D. Wethe, MD and staff restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, however if it does it is bound by the agreement.

By signing this form, I consent to the use and disclosure of protected health information about my treatment, payment and health care operations. I have the right to revoke this Consent, in writing. I understand that such a revocation shall not affect any disclosures that have already been made based on my prior Consent.

I understand if I do not sign this consent, James D. Wethe, MD may decline to provide treatment.

I understand:

- *Protected Health Information may be disclosed or used for treatment, payment or health care operations.*
- *The Practice has a Notice of Privacy Practices and I have had the opportunity to review this Notice.*
- *The Practice reserves the right to change the Notice of Privacy Practices.*
- *The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.*
- *The patient may revoke the Consent in writing with a verifiable signature on file, at any time and all future disclosures will then cease.*
- *The Practice may condition receipt of treatment upon the execution of this Consent.*

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient Relationship to Patient

_____ Witness:_____
Printed Name of Guardian Practice Representative