HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE

AMIT PARIKH, D.O.
14315 Cypress Rosehill Road, Suite 180
Cypress, Texas 77429

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE to use discloses protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). The Notice of Privacy Practices Provided by HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE describes such uses and disclosures more completely.

____ (*initial*) I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have had the opportunity to read, if so, I choose, and understand the Notice.

I have the right or review the Notice of Privacy Practices prior to signing this consent. HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE.

With this consent, HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE may email to my home or other alternative locating any items that assist the practice in carrying out Top, such as appointment reminder cards and patient statements. I have the right to request that HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE restrict how it uses or discloses my PHI to carry out TOP. The practice is not required to agree to my request restrictions, but is does, it is bound by the agreement.

By signing this form, I am consenting to allow HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE to use and disclose my PHI to carry out TOP.

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, or later revoke it, HOUSTON CENTER FOR FAMILY PRACTICE and SPORTS MEDICINE may decline to provide treatment to me.

_____ _____ _____
Signature of Patient or Legal Guardian | Relationship to Patient | Date

_____ _____
Print Patients Name | Print Name of Legal Guardian (if needed)