CompCare Medical Group, Inc.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **CompCare Medical Group, Inc.,** to use and disclose protected health information, (**PHI**), about me to carry out treatment, payment and health care operations (**TPO**).
(The Notice of Privacy Practices provided by **CompCare Medical Group, Inc.,** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **CompCare Medical Group, Inc.** 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:

CompCare Medical Group, Inc., Attn: Privacy Officer at:
15944 Los Serranos Country Club Drive
Suite 110
Chino Hills, CA 91709

With this consent **CompCare Medical Group, Inc.** 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 radiology and laboratory test results, among others.

With this consent, **CompCare Medical Group, Inc.** may mail to my home or other alternative 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 this consent, **CompCare Medical Group, Inc.** may e-mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request that **CompCare Medical Group, Inc.** restrict how it uses or discloses my **PHI** to carry out **TPO**. The practice is required to agree to my requested restrictions and is bound by this agreement.

By signing this form, I am consenting to allow **CompCare Medical Group, Inc.** to use and disclose my **PHI** to carry out **TPO**.

Additionally, I am consenting to allow **CompCare Medical Group, Inc.** to release my specifically listed **PHI** to _____**.**
(Name and relationship of person authorized to receive my PHI)

The person named above is ONLY authorized to inquire and receive PHI, pertaining to the following: (**Please list below the types of information CompCare Medical Group is authorized to release, for example: Diagnostic results; Consult notes; Hospital records; Visit reasons; Dates of Service, etc.)**

_____.

This consent expires on: _____.
(List specific date **or** write, "DOES NOT EXPIRE")

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, **CompCare Medical Group, Inc.** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable