David Bjelica, M.D.
555 Marin Street, Ste. 120
Thousand Oaks, CA 91360
Phone: (805) 449-1111
Fax: (805) 449-1136

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMANTION

With my consent, David Bjelica, M.D., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to David Bjelica, M.D. Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. David Bjelica, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised notice of Privacy Practices may be obtained by forwarding a written request to David Bjelica, M.D. privacy officer at the address above. With my consent, David Bjelica, M.D. may call my home or other designated 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 call pertaining to my clinical care, including laboratory results, among other things.

With my consent, David Bjelica, M.D., may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, David Bjelica M.D., may e-mail to my home or other designated 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 David Bjelica, M.D. restrict how it uses or discloses 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 David Bjelica, M.D., use and disclosure of my PHI to carry out TPO.

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, David Bjelica, M.D. may decline to provide treatment to me.

Signature of Patient or Legal Guardian_____

Patient's Name_____ Date_____

Print Name of Patient or Legal Guardian_____

I give consent for the release of medical information to the following name:

Name_____ Relationship_____ Date_____ Initial____