HIPAA ACKNOWLEDGEMENT

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I HEREBY ACKNOWLEDGE RECEIPT OF A WRITTEN NOTICE OF MY PRIVACY RIGHTS AND I CONSENT TO JAMSHID MADDAHI, MD using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that JAMSHID MADDAHI, MD reserves the right to change this notice of information practices and that I may obtain a copy of the revised notice by written request addressed to ANGELA MADDAHI, c/o JAMSHID MADDAHI, MD, INC., 100 UCLA Medical Plaza, #410, Los Angeles, CA 90095-7064.

I understand that I have the right to restrict how JAMSHID MADDAHI, MD, INC. uses or discloses my protected health information to carry out treatment, payment or health care operations; that JAMSHID MADDAHI, MD is not required to agree to the restrictions and; that JAMSHID MADDAHI, MD is bound by restrictions to which it agrees.

I request the following **restrictions** to how my health information is used or disclosed:

_____

_____

_____

_____

_____

_____

I have the right to revoke this consent by notifying JAMSHID MADDAHI, MD in writing, except to the extent that JAMSHID MADDAHI, MD has taken action in reliance with my consent.

_____ _____

Signature of patient or patient's representative | Date

_____ _____

Printed name of patient or patient's representative | Relationship to patient or representative's authority to act for the patient