Uzma H Rehman, D.O.
Consent Form

I consent to the use or disclosure of my protected health information (PHI) by Uzma H Rehman for the purpose of providing treatment to me, obtaining payment and for health care operations.

I understand that I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or healthcare operations of the practice. Uzma H Rehman is not required to agree to the restrictions that I may request. However, if Dr. Rehman agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that Dr. Rehman has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information collected for me and created or received by my physician, form another health care provider, and my employer or a health care clearing house. This protected health information relates to my present or future physical or mental health or condition and identifies, or there is a reasonable chance the information may identify me.

I understand I have a right to review Dr. Rehman’s Notice of Privacy practices. The Notice of Privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in healthcare operations of Dr. Rehman’s practice. The full notice of Privacy Practices can be obtained by requesting a copy at the front desk.

The Privacy Practices also describes my rights and Dr. Rehman’s responsibility to protect my Personal Health Information. Dr. Rehman reserves the right to revise or amend the Notice of Privacy Practices. Any revision or amendment will be effective for all records, past, present and future. I may obtain a revised notice of privacy practices by calling the office and requesting a revised notice asking for one at the time of my next appointment.

Signature____ Date____________________