**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**As required by the Health Information Portability and Accountability Act of 1996 ("HIPAA") and California law, Zouheir Elias, M.D. may not use or disclose your individually identifiable health information ("PHI") except as provided in his Notice of Privacy Practices, and as provided by law, without your authorization. As provided in the Notice of Privacy Practices, signing of this form constitutes your consent for Dr. Elias and his staff to use and disclose your PHI solely for the purposes of treatment, payment and health care operations.**

(1) By signing, I consent to the use and disclosure of my PHI by Zouheir Elias, M.D. for the purposes of treatment, payment and health care operations.

For the purposes of this authorization:

(a) "treatment" includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and/or consultation with and between other health care providers, including treatment by any physician who covers my practice by telephone as the on-call physician;

(b) "payment" includes activities related to determining your eligibility for health plan coverage, billing and receiving payment for your health care claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and/or pre-authorization; and

(c) "health care operations" include the necessary administrative and business functions of our office.

(2) I understand that that my diagnosis or treatment by Zouheir Elias, M.D. may be conditioned upon my consent to the use and disclosure of my PHI for the purposes of treatment, payment and health care operations.

(3) I understand that I may review Dr. Zouheir Elias' Notice of Privacy Practices for additional information about the uses and disclosures of my PHI prior to signing this Consent. By initialing here, I acknowledge that I have received a copy of the Notice of Privacy Practices. _____.

Date: _____

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Personal Representative's Relationship to Patient or Legal Authority

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**As required by the Health Information Portability and Accountability Act of 1996 ("HIPAA") and California law, Zouhcir Elias, M.D. may not use or disclosure your individually identifiable health information ("PHI") except as provided in his Notice of Privacy Practices, without your authorization. Your completion of this form means that you arc giving permission for the uses and disclosure as described below. Please review and complete this form carefully.**

(I) By signing, I authorize Zouheir Elias, M.D. to use and/or disclose any and all PHI, except as specifically provided below:

_____

(2) This authorization permits disclosure of my PHI to the following persons or entities and/or class of persons or entities:

_____

(3) This authorization permits disclosure of my PHI for the following purposes:

_____

(4) I understand that when my PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws; however, under California law, all recipients of PHI are prohibited from re-disclosing it except as specifically required or permitted by law.

(5) This authorization is in effect as of the date of signing and, unless revoked, this authorization will expire 180 days from signing plus a reasonable time to complete disclosures authorized prior to expiration.

(6) I understand that I have the right to refuse to sign this authorization and that I do not have to sign the authorization in order to receive treatment from Zouheir Elias, M.D.

(7) I understand that *I* may review Zouheir Elias, M.D. 's Notice of Privacy Practices for additional information about the uses and disclosures of my PHI prior to signing this

authorization. By initialing here, I acknowledge that I have received a copy of the Notice of Privacy Practices. _____

(8) I understand that I have the right to request restrictions on how Zouheir Elias, M.D. uses my PHI, as explained in the Notice of Privacy Practices.

(9) I understand that I am entitled to receive a signed copy of this authorization.

(10) I understand that I have the right to revoke this authorization in writing except to the extent that Zouheir Elias, M.D. has acted in reliance on this authorization. My written revocation must be submitted to the privacy officer at:

Zouheir Elias MD
18350 Roscoe Blvd
Suite 401
Northridge, CA 91325

Date: _____

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Personal Representative's Relationship to Patient or Legal Authority