Anthony T.B. Tran, M.D., F.A.C.S., P.A.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTEC HEALTH INFORMATION

With my consent, Anthony Tran, M.D., F.A.C.S., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Anthony Tran, M.D., F.A.C.S., P.A.'s 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. Anthony Tran, M.D., F.A.C.S., P.A. 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 Anthony Tran, M.D., F.A.C.S., P.A. Privacy Officer at 3300 Matlock Road, Arlington TX 76015.

With my consent, Anthony Tran, M.D., F.A.C.S., P.A. 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 others.

With my consent, Anthony Tran, M.D., F.A.C.S., P.A. 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. I have the right to request that Anthony Tran, M.D., F.A.C.S., P.A. 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 Anthony Tran, M.D., F.A.C.S., P.A.'s 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, Anthony Tran, M.D., F.A.C.S., P.A. may decline to provide treatment to me.

_____ _____

Signature of Patient of Legal Guardian Date Signed

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian