Houston Family & Geriatric Medicine

Suparna Chhibber, M.D.

Board Certified in Family Medicine
Clinical Assistant Professor,
Internal Medicine, Geriatrics and Palliative Medicine
University of Texas Medical School at Houston

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize ***SUPARNA CHHIBBER, MD, PA*** to use and/or disclose my health information, which specifically identifies me or which can reasonably be used to identify me, to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, ***SUPARNA CHHIBBER, MD, PA*** can refuse to treat me.

I have been informed that ***SUPARNA CHHIBBER, MD, PA*** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying ***SUPARNA CHHIBBER, MD, PA***, in writing, but if I revoke my consent, such revocation will not affect any actions that ***SUPARNA CHHIBBER, MD, PA*** took before receiving my revocation.

I understand that ***SUPARNA CHHIBBER, MD, PA*** has reserved the right to change her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that ***SUPARNA CHHIBBER, MD, PA*** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that ***SUPARNA CHHIBBER, MD, PA*** does not have to agree to such restrictions, but that once such restrictions are agreed to, ***SUPARNA CHHIBBER, MD, PA*** must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative ***Date***

_____ _____

Printed name of patient or patient's representative ***Relationship to patient***

909 Dairy Ashford Road, Suite 216, Houston, TX 77079
Phone: 281-493-3681 • Fax: 281-589-1465