

CONSENT OF DISCLOSURE

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to Phillip M. Levin and all health care providers furnishing care within Vascular Surgery Associates to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request. However, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling our office at (310) 652-8132 and asking that we send you one.

Print name of Patient: _____

Type of Record (operative report, discharge summary, laboratory report(s), history and physical): _____

Sign: _____ Date: _____

If you are signing as the patient's representative:

Print your name: _____

Relationship: _____

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call.

Home: _____

Work: _____

Cell Phone: _____

Other: _____

CANCELLATION

I hereby void the consent given above.

Print name of patient: _____

Signature of patient: _____ Date: _____

If you are signing as the patient's representative:

Relationship: _____

Print your name: _____

Address for cancellation will be effective, upon receipt, at the following address:

Phillip M. Levin M.D., 8631 W. Third St., Suite 615E, Los Angeles, CA 90048.