PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Rhonda Rand, M.D., Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to Rhonda Rand, M.D., Inc 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. Rhonda Rand, M.D., Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rhonda Rand, M.D., Inc. Attn: Privacy Officer at 436 North Roxbury Drive, Suite 212, Beverly Hills, CA 90210.

With my consent, Rhonda Rand, M.D., Inc may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out practice operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my consent, Rhonda Rand, M.D., Inc may mail to my home or other designated location any items that assist the practice in carrying out practice operations, such as appointment reminder cards and patient statements.

With my consent, Rhonda Rand, M.D., Inc may e-mail to my home or other designated location any items that assist the practice in carrying out practice operations, such as appointment reminder cards and patient statements. I have the right to request that Rhonda Rand, M.D., Inc restrict how it uses or discloses my Protected Health Information to carry out practice operations. 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 Rhonda Rand, M.D., Inc.'s use and disclosure of my Protected Health Information to carry out practice operations.

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, Rhonda Rand, M.D., Inc. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian   Date

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Printed Name of Patient and Legal Guardian (if applicable)