Jenny Saw, M.D.

Pediatrics

200 Jose Figueres Ave, Suite 455
San Jose, CA 95116
Tel: (408) 923-8522 Fax (408) 923-8709

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent prior to the provision of treatment or any other medical services. If you have any questions, please call your Member Services Department at the phone number located on the back of your health card.

I, _____ , currently residing at _____ _____, CA, do hereby consent to the use and disclosure of my individually identifiable health information ("Health Information'') by Dr. Jenny H. Saw for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by Provider, and/or engaging in health care operations, such as office management, credentialing case management and quality management.

I understand that ''Notice of Member's Privacy Rights & Responsibility (''Notice") describes in more detail the types of uses of disclosures of Protected Health Information involved in treatment, payment or health care operations, and that I have reviewed this Notice which is posted at the office prior to signing this consent. I understand that if I choose to not sign this consent, this provider may withhold medical services other than emergency services.

I understand that if I sign this consent, I still have the right to request a restriction on Provider's use or disclosure of any and/or all Personal Health Information to any and/or all locations, entities or persons. I further understand that Provider is not obligated to agree to my request. However, if Provider does not agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has already relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

Date Signed: _____

Patient's Name: _____ Parent/Guardian Name: _____

Patient's Date of Birth: _____ Parent/Guardian Signature: _____