Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by the office of **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to communicate with my pharmacy.

I understand that diagnosis or treatment of me by **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or to communicate with my pharmacy. The office of **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D** is not required to agree to the restrictions that I may request.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.'s** Notice of Privacy Practices prior to signing this document.

The office of **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.'s** Notice of Privacy Practices has been provided to me.

Darren E. Meyer, M.D. and Praveen Moolamalla, M.D. reserve the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices of **Darren E. Meyer, M.D. and Praveen Moolamalla, M.D.**, by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

_____
Date