

FLORY ISABEL AGUILAR, M.D.

HOAG HEALTH CENTER IRVINE

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Patient Consent Agreement

I consent to the use or disclosure of my protected health information by *Flory I. Aguilar, M.D.*, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *Flory I. Aguilar, M.D.* I understand that diagnosis or treatment of me by *Flory I. Aguilar, M.D.* may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of *Flory I. Aguilar, M.D.* *Flory I. Aguilar, M.D.* is not required to agree to the restrictions that I may request. However, if *Flory I. Aguilar, M.D.* agrees to a restriction that I request, the restriction is binding on the practice and physician and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that *Flory I. Aguilar, M.D.* has taken action in reliance to this consent.

My “protected health information” (PHI) 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 review *Flory I. Aguilar, M.D.*'s Notice of Privacy Practices prior to signing this document. *Flory I. Aguilar, M.D.*'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of *Flory I. Aguilar, M.D.* The Notice of Privacy Practices for *Flory I. Aguilar, M.D.* is also provided in a folder in the waiting room area of *Flory I. Aguilar, M.D.* This Notice of Privacy Practices also includes and describes my rights and *Flory I. Aguilar, M.D.*'s duties with respect to my protected health information.

Flory I. Aguilar, M.D. reserves 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 by requesting a revised copy by sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Flory I. Aguilar, M.D.

Diplomat, American Board of Family Practice

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