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**DHANSUKH PATEL M. D.**

**SONAL PATEL M.D.**

**Consent to Obtain External Prescription History**

I, authorize Dhansukh M.D. P.C. and Affiliated Providers to view my external prescription history via the RxHub Service. This prescription service allows providers to search all possible prescriptive medications that have been filled under my name and may include those current and discontinued in the past.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Insurance Billing**

I authorize the Dhansukh Patel M.D. P.C. to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

I authorize release of any information related to any claims to all my insurance companies or other relevant parties.

I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I permit a copy of this authorization to be used in the place of the original.

This consent will be valid until termination of care provided under Dhansukh Patel M.D. P.C.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT.

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DHANSUKH PATEL M. D.**

**SONAL PATEL M.D.**

**Consent to Use and Disclosure of Protected Health Information**

***Use and Disclosure of Your Protected Health Information:*** Your protected health information will be used by Dhansukh Patel M.D. P.C. or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

***Notice of Privacy Practices:*** You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

***Requesting a Restriction on the Use or Disclosure of Your Information:*** You may request a restriction on the use or disclosure of your protected health information. Dhansukh Patel M.D. P.C. may or may not agree to restrict the use or disclosure of her protected health information. If Dhansukh Patel M.D. P.C. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

***Revocation of Consent:*** You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***Reservation of Right to Change Privacy Practices:*** Dhansukh Patel M.D. P.C. reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and give my permission to Dhansukh Patel M.D. P.C. to use and disclose my health information in accordance with it.

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_