GROVE INTERNAL MEDICINE, INC.
8283 GROVE AVE. STE. 201
RANCHO CUCAMONGA CA 91730

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR HEALTHCARE OPERATIONS

I, , UNDERSTAND THAT AS PART OF MY HEALTHCARE, THIS PRACTICE ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT , AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT
- A MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND SURGICAL INFORMATION TO MY BILL
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED, AND
- A TOOL FOR ROUTINE HEALTHCARE OPERATIONS SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS
- AUTHORIZES PAYMENT BE MADE TO ME OR ON MY BEHALF TO GROVE INTERNAL MEDICINE, INC.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING.

I WISH TO HAVE THE FOLLOWING RESTRICTIONS TO THE USE OF DISCLOSURE OF MY HEALTH INFORMATION:

I HAVE BEEN PRESENTED WITH A COPY OF THIS PRACTICE'S NOTICE OF PRIVACY POLICIES, DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND THE CONTENTS OF THE NOTICE. I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT/ ACKNOWLEDGEMENT

NAME DATE