Shakti Narain MD PA or Bindoo Narain MD

Patient Consent Form

By signing this form, I hereby give consent to Shakti Narain MD PA or Bindoo Narain MD to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how Shakti Narain MD PA or Bindoo Narain MD may use and disclose my confidential information.

I understand that the physicians have reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me by requesting that a revised copy be sent to me in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent I writing, except to the extent Shakti Narain MD PA or Bindoo Narain MD have already used or disclosed my protected health information in reliance on my consent.

Signature of patient/legal guardian _____

Name (print) _____

Date_____

Refusal to Sign

Patient Name_____

Employee Name_____

Revocations

I hereby revoke the consent given above.

Sign_____

Print name of patient_____

If you are signing as a patient's representative:

Print Name_____

Describe Authority_____