William L. Caton III, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for William L. Caton III to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). William L. Caton III, M.D. Notice of Privacy Practices provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. William L Caton III, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to William L. Caton III, M.D., Privacy Officer at 630 S. Raymond Ave., Suite 330, Pasadena, CA 91105.

With this consent William L. Caton III, M.D. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, William L. Caton III, M.D. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that William L. Caton III, M. D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to William L. Caton III, M.D. use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, William L. Caton III, M.D. may decline to provide treatment to me.

I have been furnished and have read the **Notice of Privacy Practices.**

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

See Reverse Side

See Reverse Side