PATIENT CONSENT FORM

I grant consent to O.M.Suliman, M.D. to use and disclose my protected health information for the purposes of diagnosing or providing treatment, obtaining payment for my health care bills, conducting health care operations and medical quality assurance and peer review.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, peer review, 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.

I understand I have a right to review Dr. Suliman's Notice of Privacy Practices prior to signing this document. 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, quality assurance, peer review or in the performance of health care operations of Dr. Suliman's practice. The Notice of Privacy Practices for Dr. Suliman is provided in the waiting room and on the website @www.suliman.com. This Notice of Privacy Practices also describes my rights and Dr. Suliman's duties with respect to my protected health information.

I understand that diagnosis or treatment of me by Dr. Suliman will be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent in writing, except to the extent my protected health information has already been disclosed in reliance on this consent.

I acknowledge receipt of the Notice of Privacy rights and practices and have been given the opportunity to review that notice.

I give permission for Dr. Suliman or his staff to leave messages concerning appointment dates, treatments, diagnosis, payment information and other private health information:
Please indicate location:
______on my home phone.

______on my work phone.

______I do not give permission for Dr. Suliman or staff to leave messages on my home or work phone.

Please indicate below any individuals that we may release your medical information to:

Name:______________________________________Relationship:_____________________

Name:______________________________________Relationship:_____________________

By signing this statement I am giving Dr. Suliman and staff consent to release my personal medical information as indicated above.

___________________________________ ____________________
Signature of Patient or Personal Representative Date