

Galant & Lin, MD's Inc. Clinical Trials of Orange Co, Inc.  
Rhonda Robles, Administrator 714-771-7994 ext 139

### **Acknowledgement of Receipt of Notice of Privacy Practices**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

By signing this form, you are granting consent to Galant & Lin, MD's Inc., Clinical Trials of Orange Co, Inc. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### **General Consent for the use and disclosure of Personal Health Information (PHI)**

By signing this form, you are granting consent to Galant & Lin, MD's Inc., Clinical Trials of Orange Co, Inc. to use and disclose your protected Health Information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at 714-771-7994.

You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate: Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_