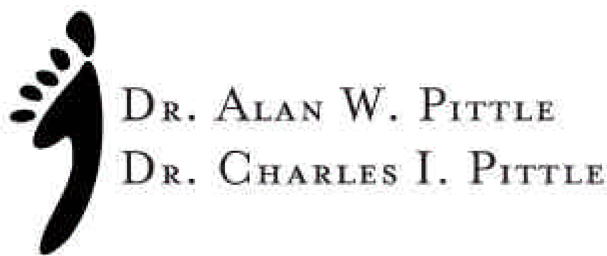
1225 E. Cliff, Suite A
915-533-1622
El Paso, Texas 79902-4734



10500 Vista Del Sol
915-592-2634
El Paso, Texas 79925

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE's Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE reserve 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 DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE Privacy Officer at 1225 E. CLIFF 2A, EL PASO, TX 79902.

With this consent, DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE 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, DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE 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.

With this consent, DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE may e-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. I have the right to request that DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE 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 DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE's 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, DR. ALAN W PITTLE and/or DR. CHARLES I PITTLE may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian