Sajad Zalzala, MD
Board Certified Family Medicine
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General Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by **Sajad Zalzala, M.D.**, his staff and designees, as may in his professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____ Initial

PHI Consent

I consent to the use or disclosure of my protected health information by **Sajad Zalzala, M.D.**, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

____ Initial

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Sajad Zalzala, M.D.** is not required to agree to the restrictions that I may request. However, if **Sajad Zalzala, M.D.** agrees to a restriction that I request, the restriction is binding on **Sajad Zalzala, M.D.**

____ Initial

____ Initial I have the right to revoke this consent, in writing, at any time, except to the extent that **Sajad Zalzala, M.D.** has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, 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, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review this office's Notice of Privacy Practices prior to signing this document. **Sajad Zalzala, M.D.**'s Notice of Privacy Practices has been provided to me. 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 or in the performance of health care operations of **Sajad Zalzala, M.D.** The Notice of Privacy Practices for **Sajad Zalzala, M.D.** is also provided by request by the receptionist. This Notice of Privacy Practices also describes my rights and **Sajad Zalzala, M.D.**'s duties with respect to my protected health information.

____ Initial

____ Initial I have been offered **Sajad Zalzala, M.D.**'s Notice of Privacy Practices for review.

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Signature of Patient of Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Description of Personal Representative's Authority**