510 W PUEBLO STREET SANTA BARBARA CA 93105
PHONE 805.687.5500 / FAX 805.682.3295 / www.sbobgyn.com

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Protected Health Information: Your protected health information will be used by Dr. Ayesha Shaikh and/or her designated staff, or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use and Disclosure of Your Information: You may request a restriction on the use or disclosure of your protected information. Ayesha Shaikh, M.D. may or may not aagree to restrict the disclosure of your protected information.

If Ayesha Shaikh, M.D. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Rights to Change Privacy Practices. Ayesha Shaikh, M.D. reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and give my permission to Ayesha Shaikh, M.D. and/or her designated staff to use and disclose my health information:

Name of Patient (Print or Type)

Signature of Patient or Patient Representative & Relationship / Date