Bruce Hubbard, M.D., Inc.

Consent to Use or Disclose Health Information

I authorize Bruce Hubbard, MD Inc. and its providers to use and disclose my medical information for the purposes of Treatment, Payment, and Health Care Operations.*

*__Treatment__ includes activities performed by a healthcare provider, nurse, office staff and other types of healthcare professionals providing care to you, coordinating or managing your care with third parties (e.g. pharmacies, laboratories), and consultations with and between other healthcare providers. This consent includes treatment provided by any physician who covers my practice by telephone as the on-call physician.

*__Payment__ includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification or pre-authorization.

*__Health Care Operations__ include the necessary administrative and business functions of our office.

I further authorize Dr. Bruce Hubbard, Dr. Ann Wycoff, and Rizwan Khan, PA-C to disclose health and medical information for the purpose of coordinating my care to:

My psychologist/therapist: _____ Telephone: _____

My primary care physician: _____ Telephone: _____

Other: _____ Telephone: _____

These should include all progress notes, laboratory tests, medical records, psychological tests, and hospital admission discharge summaries unless otherwise indicated as follows:

_____

This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above mentioned. This also includes any consultative telephone conversations.

I understand that the medical records and information released may contain information pertaining to psychiatric, drug and/or alcohol-related treatment.

You are hereby released from all legal liability that may arise from the release of the information requested.

This release is valid for one year past the signature date.

A copy of this true medical release shall be as valid as an original of the same.

OFFICE (619) 295-8005 FAX (619) 297-1700 1565 Hotel Circle So. Ste 310, San Diego, CA 92108
http://brucehubbardmd.com

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Patient, please check one:

_____ ***I agree to release this information to the physician or therapist listed above. I understand that I have the right to revoke this consent, provided that I do so <u>in writing,</u> except to the extent that Dr. Bruce Hubbard or Rizwan Khan, PA-C has already used or disclosed the information in reliance on this consent.***

_____ ***I do not agree to release this information to the physician or therapist listed above.***

_____ ***I do not have a physician.***

_____ ***I do not have a therapist***

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