Consent for the purposes of treatment, payment and healthcare operations

I consent to the use or disclosure of my protected health information by Peter Alan Krause Medical Corporation for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for the medical practice. I understand that diagnosis or treatment of me by Peter Alan Krause Medical Corporation may be conditioned upon my consent evidenced by my signature on this document.

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 medical practice. Peter Alan Krause Medical Corporation, is not required to agree to the restrictions that I may request. However, if the medical practice agrees to the restriction I request, the restriction is binding on Peter Alan Krause Medical Corporation and employees.

I have the right to revoke this consent, in writing, at any time except to the extent that Peter Alan Krause Medical Corporation has taken action in reliance of this consent. Otherwise, this consent is valid for a period not to exceed 6 years from the date signed.

My 'protected health information' means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my health plan, my employer or a health care clearinghouse. This protected health information, relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have the right to review Peter Alan Krause Medical Corporation Notice of Privacy Practices prior to signing this document. The medical practice's Notice of Privacy Practices will be provided to me to review, if requested. The Notice of Privacy Practices describes in more detail the types of uses and disclosures of my protected health information that will occur I my treatment, payment of my bills or in the performance of the healthcare operations of Peter Alan Krause Medical Corporation. The Notice of Privacy Practices also describes my rights and Peter Alan Krause Medical Corporation with respect to my protected health information.

Peter Alan Krause Medical Corporation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office or requesting via the patient portal to be sent in the mail, by email, fax or at your next visit. Any questions regarding this document or the Notice of Privacy Practices should be directed to our privacy officer, Chelsea Krause at 805-623-5010 or chelsea@dockrause.net

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Patient Signature Patient Name (Printed legible)

Date: __________________ Restrictions: NO ☐ YES ☐

List restriction type: