L. Scott Stoney, M.D. ***CALIFORNIA REHABILITATION, INC.
Physical Medicine and Rehabilitation

361 Hospital Rd, Suite #425
Newport Beach, CA 92660
(949) 548-4580

PATIENT CONSENT FOR USE AND DISCLOURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for California Rehabilitation, Inc to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (California\ Rehabilitation, Inc.'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. California Rehabilitation, Inc reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to California Rehabilitation, Inc Privacy Officer at [*361 Hospital Rd Suite 425, Newport Beach CA 92663*].

With this consent, California Rehabilitation, Inc 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, California Rehabilitation, Inc 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, California Rehabilitation, Inc 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 California Rehabilitation, Inc restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions to California Rehabilitation, Inc, but if it does, it is bound by this agreement. By signing this form, I am consenting to California Rehabilitation, Inc.'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, California Rehabilitation, Inc my decline to provide treatment to me.

Signature of Patient or Legal Guardian

Today's Date: _____/_____/_____ **_____**

Patient's Name

Print Name of Patient or Legal Guardian