Patient Consent

Kevin W. Louie, M.D. A Professional Corporation
2100 Webster Street, Suite 117, San Francisco CA, 94115

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations.
Protected health care information is individually identifiable information we create or receive, including information related to your physical and/or mental health that we use to provide healthcare services to you as well as obtain payments for services provided.

With this consent, Dr. Louie may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including tests and laboratory results among others.

With this consent, Dr. Louie may mail to my home or other alternative location any items that assist the practice in carrying out healthcare operations, such as patient statements as long as they are marked Personal and Confidential. In addition, I give Dr. Louie permission to speak with the following family members, spouse, roommate, etc. regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not sign this Consent Form, we have the right to refuse treatment unless we are required by law to treat you. You have the right to revoke this consent in writing except where we have already made disclosures in reliance to your prior consent. You may use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter with written request.

I have read and understand this policy as outlined above.

Signature of
Patient/Legal Guardian: _____ Relationship: _____

Patient Name (print): _____ Date: _____