Temecula Valley Family Physicians, Inc. Privacy Officer
31720 Temecula Parkway Suite #203
Temecula, California 92592
Tel 951-302-4700 Fax 951-302-4701

Patient's Initials: __________

With this consent, I give my permission for Temecula Valley Family Physicians, Inc and Dr. Curtiss W. Combs to **(PLEASE INITIAL ONE OR ALL THE BOXES THAT APPLY):**

[ ] **Call my home** or other **alternative location** and **leave a message on voice mail, answering machine, Texting**, or in person, in reference to any information that assists the practice in carrying out treatment, payment, and healthcare operations to include, but not limited to appointment reminders, insurance concerns/questions, and calls pertaining to my clinical care to include, but not limited to laboratory results.

[ ] **Mail to my home or other alternative location** any information that assists the practice in carrying out treatment, payment, or healthcare operations.

[ ] **Release or communicate** information by **telephone, E-mail, Texting or in writing**, any information that assists the practice in carrying out treatment, payment, or **healthcare information with my spouse, family member or other representative that I have indicated below:**

(IF A FIRST NAME, LAST NAME, AND RELATIONSHIP TO THE PATIENT IS NOT LISTED, ONLY THE PATIENT CAN ACCESS HIS/HER RECORDS. IF YOU LIKE US TO CONTACT YOU THROUGH EMAIL / TEXTING PLEASE LIST YOUR EMAIL CELL NUMBER). *Mobile information will not be shared with any third parties.

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PATIENT'S EMAIL: ____

I have the right to request that Temecula Valley Family Physicians, Inc./Dr. Curtiss W. Combs' practice restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and/or healthcare operations. 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, Temecula Valley Family Physicians, inc./Dr. Curtiss W. Combs' practice may decline to provide me treatment to me.

Date: ________________

Patients
Name:____

Date of Birth: _____________________

Signature of Patient/ Guardian:
____