Acknowledgement of Receipt of the Notice of Privacy Practices

Holistic Family Doctor
Lonna Larsh, MD
Amber Weiss, PA-C

4450 Capitola Rd., Ste #105
Capitola, CA 95010

710 River St, Suite 10
Santa Cruz, CA 95060

I have reviewed the notice of Privacy Practices regarding my Protected Health Information from Lonna Larsh, MD/Amber Weiss, PA-C. I hereby give my consent for Amber Weiss, PA-C to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the above listed medical providers or their representatives 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 items may include appointment reminders and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Lonna Larsh, MD or Amber Weiss, PA-C may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory results and patient statements. Electronic mail may be used for these purposes as well.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lonna Larsh, MD or Amber Weiss, PA-C may decline to provide treatment to me.

________________________________ ____________________
Patient Name Date of Birth

________________________________ ____________________
Guardian Name Relationship

________________________________ ____________________
Patient/Guardian Signature Date

Received by: ______________________ on ____________________
Lonna Larsh, MD Date
Amber Weiss, PA-C