Mobile **Doctor** Medical Clinic
In-home medical services

Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, HAVE RECEIVED A COPY OF RANCHO SANTA FE MEDICAL GROUP, INC. DBA MOBILE DOCTOR MEDICAL CLINIC NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature of Patient Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable** has taken action in reliance on this consent.

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

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority