

**ANTHONY K. AHN, M.D.**

*Diplomate, American Board of Orthopedic Surgery*  
Beach Cities Orthopedic & Sports Medicine

**PATIENT INFORMATION CONSENT FORM**

I have read and fully understand Anthony K. Ahn, M.D.'s Notice of Privacy Practices. I understand that Anthony K. Ahn, M.D. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Anthony K. Ahn, M.D. will consider request for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes a noted in Anthony K. Ahn, M.D.'s Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

In compliance with new federal and state regulations, this is to confirm that I have received the following documents:

- A. Notice of Privacy Practice
- B. Patient Information Consent Form

AHN MD, ANTHONY

Patient Name

03-23-2016

Signature

Date

Witness

Date