**ROBERT J. KLEIN, DO**
**1652 42nd Street, NE**
**Suite A**
**Cedar Rapids, IA 52402-3075**

## PATIENT CONSENT

I authorize the release of any protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to request restrictions on how the practice uses or discloses my PHI to carry out TPO. However, Robert J. Klein, DO is not required to agree to my request. If I decline to sign this consent, Robert J. Klein, DO may decline to provide treatment to me. This authorization will remain valid indefinitely or until revoked.

_____ _____
Signature of Patient or Legal Guardian Date

## INSURANCE AUTHORIZATION

I authorize payment of medical benefits to Robert J. Klein, DO for services rendered. This authorization will remain valid indefinitely or until revoked

_____ _____
Signature of Patient or Legal Guardian Date

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of Robert J. Klein, DO's Notice of Privacy Practices.

_____
Patient's Name

_____ _____
Signature of Patient or Legal Guardian Date