AUTORIZACION DEL PACIENTE PARA PERMITIR
EL USO Y DIVULCION DE INFORMACION DE SALUD.

Este documento autoriza la divulgación y/o el uso de información de la salud, sobre usted.
La falta de información pedida puede invalidar esta autorización.

Nombre del Paciente: ______________________ Fecha de Nacimiento ______________

Dirección ______________________ Número de Seguro Social ____-____-____

____

Autorizo a: ______________________ ______________________
Nombre de persona/Organización *Dirección*

______________ ______________ ______________________
Teléfono *Fax* *Ciudad* *Estado, Código Postal*

Divulge información a: Rancho Paseo Medical Group Teléfono: 951-769-0079
264 N. Highland Springs Ave., 5A, Banning, CA 92220 Fax: 951-845-6750

La información siguiente:

a. ☐ Toda la información de la salud referente a mi condición médica del historial, mental o física

o ☐ Solamente los siguientes expedientes o los tipos de información de la salud (incluya la fecha o fechas del tratamiento):______________________

b. Autorizo específicamente divulgo de la información siguiente (cheque como apropiado):
☐ Información del tratamiento de la salud mental
☐ Resultados de la prueba del VIH
☐ Información del tratamiento del alcohol/de la droga

Se requiere una autorización separada de autorizar el acceso o el uso de las notas de la sicoterapia. Propósito del uso o del acceso pedido: Petición paciente ☐; O ☐ otro ______________________

Fecha de vencimiento: ______________ (Esta autorización quedará anulada y expirar*á* en 6 meses a menos que se indicare contrariamente).

- Puedo rechazar firmar esta autorización. Mi denegación no afectará a mi capacidad de obtener el tratamiento o pago o elegibilidad para los beneficios.
- Puedo examinar u obtener una copia de la información de la salud que me están pidiendo.
- *Puedo revocar esta autorización pero* debo hacerlo por escrito y presentar mi *revocación* en *este* domicilio
  Rancho Paseo Medical Group, 264 N. Highland Springs Ave. 5A, Banning, CA 92220
- *Mi revocación tomará efecto* en cuanto sea recibida, excepto hasta el punto de otros hayan actuado en confianza sobre esta autorización.
- Tengo una derecha a y recibiré una copia de esta autorización.
- La información divulgada conforme a esta autorización se podía re-divulgar por el recipiente. Tal re-acceso no es protegido por la ley de California y se puede en algunos casos proteger no más por ley de secreto federal (HIPAA).

Si esto esta marcado☐, el solicitante recibirá la remuneración para el uso o la divulgación de mi información.

Firma: ______________________ Nombre: ______________________
(paciente/representante/esposo/partido financieramente responsable)

Si es firmado por alguien con excepción del paciente, indique su relación legal al paciente: ______________

Firma del testigo: ______________________ Fecha: ______________________

Rancho Paseo Medical Group

REGISTRO DE PACIENTES

INFORMACIÓN DEL PACIENTE					
PRIMER NOMBRE INICIAL APPELLIDO(S)	ESTADO CIVIL ☐ SOLTERO-A ☐ CASADO-A ☐ SEPARADA ☐ VUIDO-A	FECHA DE NACIMIENTO	EDAD	SEXO	
DOMICILIO	NUMERO DE TELÉFONO	NUMERO DE SEGURO SOCIAL			
CIUDAD ESTADO ZONA POSTAL	NUMERO DE CELULAR				

SI ES MENOR DE 18 AÑOS: QUIEN ES LA PERSONA RESPONSIBLE?			EMPLEADOR	
APPELLIDO(S) Y NOMBRE			NOMBRE	
DOMICILIO	FECHA DE NACIMIENTO		DOMICILIO	
CIUDAD ESTADO ZONA POSTAL			CIUDAD ESTADO ZONA POSTAL	
RELACIÓN AL PACIENTE	SEGURO SOCIAL	TELÉFONO	TELÉFONO	OCUPACIÓN

ESPOSO-A DE PERSONAL RESPONSIBLE			EMPLEADOR DE ESPOSO-A	
APPELLIDO(S) Y NOMBRE			NOMBRE	
DOMICILIO	FECHA DE NACIMIENTO		DOMICILIO	
CIUDAD ESTADO ZONA POSTAL			CIUDAD ESTADO ZONA POSTAL	
RELACIÓN AL PACIENTE	SEGURO SOCIAL	TELÉFONO	TELÉFONO	OCUPACIÓN

EN CASO DE EMERGENCIA, NOTIFICAR			
NOMBRE	RELACIÓN AL PACIENTE	NOMBRE	RELACIÓN AL PACIENTE
DOMICILIO	TELÉFONO	DOMICILIO	TELÉFONO
CIUDAD ESTADO ZONA POSTAL	CELULAR	CIUDAD ESTADO ZONA POSTAL	CELULAR

INFORMACIÓN DE SEGURO	PRIMARIO	SEGUNDARIO	INFORMACIÓN DE MISC.
NOMBRE DE ASEGURANZA			
NOMBRE DE SUSCRIPTOR(ORA)			
SEGURA SOCIAL DE SUSCRIPTOR(ORA)			
FECHA DE NACIMENTO DE SUSCRIPTOR(ORA)			PARA OFICINA (OFFICE USE ONLY)
EMPLEADOR DE SUSCRIPTOR(ORA)			
RELACIÓN DE SUSCRIPTOR(ORA)			

INSURANCE AUTHORIZATION, ASSIGNMENT, AND MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.
“Special authorization is needed to release any and all information regarding patients that are seen by a Behavioral Health Provider.
ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to Rancho Paseo Medical Group for services provided to me by Rancho Paseo Medical Group. I understand that I am financially responsible to Rancho Paseo Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits in the event of default, I agree to pay all costs of collection, including reasonable attorney’s fees. This authorization will remain in effect until revoked in writing by the undersigned.

FECHA ______________________ FIRME AQUI ______________________

Rancho Paseo Medical Group. 264 N. Highland Springs Ave. 5A. Banning, CA 92220

FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with Federal Truth-in-Lending Act.

Rancho Paseo Medical Group shall charge a FINANCE CHARGE on any part of the “previous balance” at the periodic rate of 1¼% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any “previous balance” as shown on the periodic statement, which is paid 90 days from the first billing of the “previous balance” or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the “previous balance” which is more than 90 days unpaid and then to that portion of the “previous balance” which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and then finally to credit.

You may pay your entire balance at any time.

Any credit balances of $5.00 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of Insurance. Rancho Paseo Medical Group cannot accept the responsibility for collecting your Insurance claims or negotiation of a settlement on a disputed claim. Notwithstanding Insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by Insurance benefits.

Rancho Paseo Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Rancho Paseo Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued to the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient’s Signature: ______________________________________ Date: ____________________

CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Rancho Paseo Medical Group professionals and their assistants, appointees, or consultants as is necessary in their judgment.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments of examination by Rancho Paseo Medical Group.

3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Further, if I don’t fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Rancho Paseo Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.

5. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name: ____ Date of Birth: ______________________

Signature of Patient: ____ Date: ____________________________

Signature of Patient or Guardian: ________________________________ Relationship: ______________________

Signature of Witness: ____ Date: ____________________________

ADVANCE DIRECTIVE QUESTIONNAIRE / *CUESTIONARIO SOBRE DIRECTIVAS AVANZADAS*

1) Have you formulated an Advance Directive?
Ha formulado usted una Directiva Avanzada? ☐ *No* ☐ *Yes / Si*

2) If you have formulated an Advance Directive, please check the type of directive:
Si ya ha formulado una Directiva Avanzada, por favor marque el tip que tiene
:
   a) Durable power of attorney for health care: /
   Poder Durable de Abogado para Cuidado de Salud: ____

   b) California Natural Death Act: / *Acta de California de Muerte Natural*
   ____

   c) Living Health Care Will: / *Testamento de Cuidado de Salud en Vida:* ______________________________

   d) Other: / *Otro:* ____

3) If you have formulated an Advance Directive, you hereby agree to furnish _______________________________ with a copy within ______days. /
Si ya usted ha formulado una Directiva Avanzada, acepta entregarnos una copia a _________________________*dentro de* ________________ *dias.*

4) If you change, amend, alter or cancel your Advance Directive, you hereby agree to notify ______________________ and provide ________________ with a copy as soon as possible so that your physician will be able to comply with your wishes. /
Si cambia, enmienda, altera o cancela su Directiva Avanzada acepta notificar a __________________________
Y proveer a _______________________ *a con una copia tan pronto le sea possible para que su medico de cabecera pueda cumplur con sus deseos.*

5) Expiration date of Advance Directive, if any: ____________________________________.
(If the Advance Directive was formulated before 1991, it is "good" for only seven years. Advance Directives formulated after 1991 are "good" indefinitely; unless you change/amend/cancel the Directive) /
Fecha de expiracion de la Directiva Avanzada, si la tiene ___________________________________.
(Si su directivaAvanzada fue formulada antes de 1991, estara vigente por solo 7 anos. Si fue formulada despues de 1991, estas estaran vigentes indefinidamente a menos de que usted las cambia, enmiende o cancele).

6) I would like more information about Advance Directives. /
Quisiera mas informacion sobre Directivas Avanzadas. ☐ *No* ☐ *Yes / Si*

7) I do not wish to formulate or have an Advance Directive. /
No me interesa ninguna information acerca de Directivas Avanzadas. ☐ *No* ☐ *Yes / Si*

Patient Name / *Nombre de Paciente*: __________________________________

Patient Signature / *Firma de Paciente*: _______________________________ Date / *Fecha:* _____________

Adult TB Exposure Risk Assessment

(Evaluation Questionnaire to determine if Mantoux tuberculin skin test (TST) is indicated.)

Name: ____ Medical Record #: _______________________
Age _________________ DOB: ______________________ DOS: ___________________

The health care worker (HCW) is to ask the following questions during each periodic health assessment.

1. Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB disease? Yes______ No______
2. Do you have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? Yes______ No______
3. Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? Yes______ No______
4. Do you live in out of home placements (such as board & care or residential facilities)? Yes______ No______
5. Do you have HIV infection, or other immunosuppressive condition? Yes______ No______
6. Do you live with someone with HIV seropositivity? Yes______ No______
7. Do you live, or frequently visit, with persons who have been incarcerated in the last 5 years? Yes______ No______
8. Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes? Yes______ No______
9. Do you consume alcoholic beverages? Yes______ No______ If so, how much? ___________________________

INSTRUCTIONS TO HEALTH CARE WORKER:
Administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a YES response) UNLESS:

1. The patient has a previous DOCUMENTED* positive Mantoux TST, or
2. The patient has had a TST within the last year.

NOTE:
Trained medical personnel must read the skin test.

*DOCUMENTED = Record indicating the date of Mantoux and the millimeter result.

Health Care Worker Completing form:
Completing form: ____________________________________ Date: ____

ADULT HEALTH HISTORY / HISTORIA DE SALUD ADULTO

Name/Nombre ______________________ Age/Edad ________ DOB/Cuando Nacio ____________ Date/Fecha ____________

HISTORY OF PAST ILLNESS: Have you had?/ENFERMEDADES PASADAS: Ha tenido

Measles/Sarampion	☐ No	☐ Yes/Si	Rheumatic fever/Fiebre Reumatica	☐ No	☐ Yes/Si
Mumps/Paperas	☐ No	☐ Yes/Si	Heart Disease/Enfermedad del Corazon	☐ No	☐ Yes/Si
Chickenpox/Viruela	☐ No	☐ Yes/Si	Tuberculosis	☐ No	☐ Yes/Si
Diabetes	☐ No	☐ Yes/Si	Venereal Disease/Enfermedad Veneria	☐ No	☐ Yes/Si
Strokes/Embolio	☐ No	☐ Yes/Si	Serious Disease/Enfermedad Graves	☐ No	☐ Yes/Si

Ever Hospitalized/Has sido hospitalisado ☐ No ☐ Yes/Si Explain/Explicacion ____________________

Ever had surgery/Ha tenido operaciones ☐ No ☐ Yes/Si Explain/Explicacion ____________________

Had broken bonesiHa tenido fracturas ☐ No ☐ Yes/Si Explain/Explicacion ____________________

Head concussions or injuries/
Golpes o Heridas de cabeza ☐ No ☐ Yes/Si Explain/Explicacion ____________________

Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetano ____________________

Date of Last PAP Smear/La Fecha de papanicolou exam de cancer. ____________________

Date of Last Mammogram/Mammographia ____________________

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had? Ha habido en su familia?

Cancer	☐ No	☐ Yes/Si	Who/Quien? ____________
Diabetes	☐ No	☐ Yes/Si	Who/Quien? ____________
Tuberculosis	☐ No	☐ Yes/Si	Who/Quien? ____________
Heart trouble/Enfermedad del Corazon	☐ No	☐ Yes/Si	Who/Quien? ____________
High blood pressure/Presion alta	☐ No	☐ Yes/Si	Who/Quien? ____________
Stroke/Embolio	☐ No	☐ Yes/Si	Who/Quien? ____________
Convulsions/Epilepcia	☐ No	☐ Yes/Si	Who/Quien? ____________
Suicide/Suicidio	☐ No	☐ Yes/Si	Who/Quien? ____________

SOCIAL HISTORY/HISTORIA SOCIAL:

☐ Single/Soltero ☐ Married/Casado ☐ Separated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo

Alcoholic Beverages/Bebidas Alcolicas: ☐ Never/Nunca How much/Cuanto? ____________

Tobacco or Cigarettes/Tobacco o Cigarillos: ☐ Never/Nunca. How much/Cuanto? ____________

Are you sexually active?/Esta sexualmente activa(o)? ☐ Never/Nunca. How much/Cuanto? ____________

What is your job?/Cual es su trabajo? ____________________

Education Level/Nivel de Education: 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ 11☐ 12☐ College/Colegio Superior 1☐ 2☐ 3☐ 4☐

Ethnic Background/Nacionalidad: ☐ American Indian ☐ Asian ☐ Filipino ☐ Pacific Islander ☐ Black ☐ Hispanic ☐ White

SYSTEMIC REVIEW GENERAL? REVISION DE SYSTEMAS:

Recent weight change/Reciente cambio de peso? ☐ No ☐ Yes/Si

Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida? ☐ No ☐ Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS?

Skin/Piel	No	☐ Yes/Si	Explain/Explicacion ____________
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nariz-Garganta	No	☐ Yes/Si	Explain/Explicacion ____________
Neck/Cuello	No	☐ Yes/Si	Explain/Explicacion ____________
Lungs/Pulmones	No	☐ Yes/Si	Explain/Explicacion ____________
Heart and Circulation/Corazon 0 Circulacion	No	☐ Yes/Si	Explain/Explicacion ____________
Blood/Sangre	No	☐ Yes/Si	Explain/Explicacion ____________
Emotions/Emociones	No	☐ Yes/Si	Explain/Explicacion ____________
Nerves/Nervios	No	☐ Yes/Si	Explain/Explicacion ____________
Muscles and bones/Musculos o huesos	No	☐ Yes/Si	Explain/Explicacion ____________
Stomach and Bowels/Estomago o Intestinos	No	☐ Yes/Si	Explain/Explicacion ____________
Sex Organs/ Organos Sexuales	No	☐ Yes/Si	Explain/Explicacion ____________
Urinary/Urinaros	No	☐ Yes/Si	Explain/Explicacion ____________
Any other/Cualquier otro	No	☐ Yes/Si	Explain/Explicacion ____________

ALLERGIES OR REACTIONS TO FOOD OR MEDICATION/REACCIONES A ALIMENTOS O MEDICINAS

PATIENT SIGNATURE/FIRMA ____________________ DATE/FECHA ____________

DOCTOR SIGNATURE ____________________ DATE/FECHA ____________

RANCHO PASEO MEDICAL GROUP
264 N. HIGHLAND SPRINGS AVE #5A
BANNING, CA. 92220
(909) 769-0079 FAX (909) 845-6750

Medi-Cal ☐
Other ☐

Health History
(Confidential)

Name__________ Age of patient__________ Date of Visit__________

Personal History

Birthplace__________ Birthdate__________
Education__________ Marital Status__________
Health of Spouse__________
Sleep (usual hours)____ Aids to sleep__________
Recreation__________
Exercise__________
Religion__________

Personal Family Health History

Check (✓) if you or your blood relatives have or have had any of the following:

You	Disease	Family	Relation to
	AIDS, HIV positive		
	Alcohol dependency		
	Allergies, hayfever		
	Anemia		
	Arthritis, gout		
	Asthma		
	Bleeding tendency		
	Cancer		
	Chronic lung disease		
	Convulsive disorder		
	Diabetes		
	Drug dependency		
	Heart disease		
	High blood pressure		
	Kidney disease		
	Leukemia		
	Mental illness		
	Migraines		
	Obesity		
	Peptic ulcer		
	Stroke		
	Thyroid trouble		
	Tuberculosis		
	Other		

Hospitalizations & Surgeries

Year	Hospital	Reason for hospitalization

Have you ever had a blood transfusion? __________
If yes, please give approximate dates: __________

Medicines Taken Regularly

Name	Dose	Reason

Allergies & Sensitivities

List all substances, including drugs, to which you have had an adverse reaction

Substance	Describe reaction

Occupational Concerns

Your occupation __________
Check (✓) if your works exposes you to the following:

✓	Exposure	Describe
	Hazardous	
	Heavy lifting	
	Stress	
	Other	

Health Habits

Describe how much of each of these substances you use:
Caffine__________
Tobacco__________
Alcohol__________
Other__________

Circle "Yes" or "No"

Have you ever felt you should cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hang-over?	Yes	No

Rancho Paseo Medical Group
264 N. Highland Springs Ave., Ste. 5-A
Banning, CA 92220
951-769-0079, Fax: 951-845-6750

Notice of Privacy Practices
To The Patients of Rancho Paseo Medical Group. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

Name of Patient ____________________________________

Patient's Signature ___________________________________

Date ____

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Rancho Paseo Medical Group, 264 North Highland Springs Ave., Ste. 5, Banning, California 92220 (951) 769-0079. Attention Administrator or Safety Officer.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Rancho Paseo Medical Group, 264 North Highland Springs Avenue, Banning, California 92220 (951) 769-0079. Attention: Administrator or Practice Privacy Officer. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Rancho Paseo Medical Group, 264 North Highland Springs, Banning California 92220 (951) 769-0079. Attention Administrator or Practice Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Rancho Paseo Medical Group, Attention Administrator or Practice Privacy Officer, (951) 769-0079