CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

_________________________Patient giving consent_________________________________

Patient Name: ____

Address:____

Telephone #:___________________________E-Mail_________________________________

Patient's SSN#:_________________________ Patient's Chart #__:_______________________

________________________To the patient-please read carefully_______________________

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Privac Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy practices, we will issue a new Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

Office Manager
Telephone (609) 488-2325
Fax (609) 488-2342
Address: 249 S. Main St. #4, Barnegat, NJ 08005

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice submitted to the contact person above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

______________Signature of Patient or Patient's Personal Representative________________

I , ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:____ Date:_________________

If Personal Representative: ____________________________ Date:_________________

Print ____

Relationship to Patient:_______________________________

You are entitled to a signed copy of this Consent