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2189 Riverton Road
Cinnaminson, NJ 08077

HIPAA PATIENT CONSENT

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation.

I have been informed by you of the Notice of Privacy Practices available for review. I also understand that I may request in writing: restriction, usage and disclosure of my information; and that you are not required to agree to my request. This consent may be revoked, by me, at any time.

Patient Name: _____
Date:_____

Signature: _____
Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize you to disclose and/or discuss the informational items checked below with:

Name: _____

Relationship to Patient: _____

____ Account/ Ledger

____ Appointment schedule/ confirm

____ Medications

____ Treatment: proposed or current

This authorization shall remain in effect until canceled, in writing, by me. _____
(Initial)

Signature: _____