



Today's Date: _____

286 New Brunswick Ave
Hopelawn, NJ 08861
Phone # 732-910-1312 Fax# 877-423-5835

HIPAA Compliance Patient Consent Form

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? (YES)(NO)

May we leave a message on your answering machine at home or on your cell phone? (YES)(NO)

May we discuss your medical condition with any member of your family? (YES)(NO)

If YES, please name the members allowed:

Signature: _____ Date: _____