Consent To Use or Disclose Information For Treatment, Payment and Health Care Operations

Patient Name _____

Persons or Organization Granted this Consent:
Holmdel Pediatrics L.L.C.
719 N. Beers St., Suite 1E
Holmdel, NJ 07733

Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as “health care operations” (for example, quality improvement activities).

With this consent form, we are asking you to make the permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review that Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at anytime. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment or healthcare operations. However, we do have to agree to these restrictions. If we do agree to a restriction that agreement is binding.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide healthcare services if this consent is not granted or if the consent is later revoked.

_____

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____

Signature of Patient/Guardian Date

Relationship to patient _____

I wish to have the following restrictions to the use or disclosure of my health information

_____

_____

For office use only:
( ) consent received by: _____ Date: _____
( ) consent added to patient medical record on _____
( ) consent refused by patient