

MORRISTOWN MEDICAL GROUP, P.C.

HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to view such Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you are taking action relying on this consent.

Patient Name (Please Print): _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____

95 MADISON AVENUE
MORRISTOWN, NJ 07960
PHONE: 973-267-1010
FAX: 973-267-5521

ONE ANDERSON ROAD, SUITE 102
BERNARDSVILLE, NJ 07924
PHONE: 908-696-0808
FAX: 908-696-9943

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Patient Consent Form

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information (PHI) to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient's Signature

Date

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

Initial here _____

I authorize the following person(s) to receive medical information on my behalf:

Initial here _____

FOR OFFICE USE ONLY

- [] Consent received by _____ Date: _____
[] Consent added to patient's medical record on: _____
[] Consent refused by patient.

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