# *ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY*

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## CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPPA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment, it may also be used for payment and operational purposes, I have the right to review the Adult and Pediatric Allergist of Central Jersey's "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practices. Changes in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment, or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special

Restriction:_____.

I understand that from time to time my physician and his/her staff may inform me of new drugs, treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me of such new drugs, treatments or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my medical record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Patients Name: _____ Date: _____
Signature: _____