Montgomery Internal Medicine Group

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Montgomery Internal Medicine Group, PC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Montgomery Internal Medicine's, PC Notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Montgomery Internal Medicine Group, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our offices at 727 State Road, Princeton, NJ 08540 or 719 Rt. 206, Suite 100, Hillsborough, NJ 08844.

With my consent, Montgomery Internal Medicine Group, PC, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I wish to be contacted in the following manner (mark all that applies):

Home telephone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

Cell phone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

Work phone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

I grant permission for you to discuss my care with the following person(S):

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

By signing this form, I am consenting to Montgomery Internal Medicine Group's, PC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Montgomery Internal Medicine Group, PC may decline to provide treatment to me.

_____ _____ _____
Print Name of Patient/Legal Guardian Effective Date of Consent Expiration of Consent

_____
Signature of Patient/Legal Guardian