Plainsboro Family Physicians

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Plainsboro Family Physicians to use and disclose **P**rotected **H**ealth **I**nformation (**PHI**) about me to carry out **T**reatment, **P**ayment and health care **O**perations (**TPO**). (Plainsboro Family Physicians' Notice of Privacy Practices provides 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. Plainsboro Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Plainsboro Family Physicians, 666 Plainsboro Road, Suite 1316, Plainsboro, NJ 08536.

With this consent Plainsboro Family Physicians may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent Plainsboro Family Physicians may mail or fax to my home or other alternative location any items that assist the practice in carrying out **TPO**, such appointment reminder cards and patient statements as long as they are marked personal and confidential.

I have the right to request that Plainsboro Family Physicians restrict how it uses or discloses my **PHI** to carry out **TPO**. However, the practice is not required to agree to my requested restriction, but if it does it is bound by this agreement.

By signing this form, I am consenting to Plainsboro Family Physicians' use and disclosure of my **PHI** to carry our **TPO**.

X______________________________ ____________________

Signature of Patient or Legal Guardian Date

______________________________ ______________________________

Print Patient Name Print Name of Legal Guardian

_____ **YES:** By ***INITIALING*** here I am consenting to allow Plainsboro Family Physicians to place referrals and other **PHI** in a tamper evident envelope and place it in an unlocked box outside our office door to facilitate pick up by myself or my representative when the office is closed.

_____ **NO:** No I do not consent to having referrals and other PHI placed in the unlocked box. Please keep any referrals or other **PHI** inside the office and I will arrange for pick up when the office is open.

Plainsboro Family Physicians

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________, have received a copy of Plainsboro Family Physicians' Notice of
Patient Name

Privacy Practices.

______________________________*
Signature of Patient or Representative

____
Date

*If the person signing is not the patient, please print your name and relationship to the patient:____

FOR OFFICE USE:

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:____
____
____