100 US Highway 46 East, Building B Ste 204, Mountain Lakes, NJ 07046
◆ Phone (973) 917-3200 ◆ Fax (973) 917-3201 ◆ www.mtlakesmedical.com
No appointment necessary. Hours: Mon 8am-8pm, Tues - Thurs 8am-6pm, Fri 8am-3pm, Sat & Sun 9am-2pm

Patient Consent for Use and Disclosure of Protected Health Information (HIPAA)

I hereby give my consent for Mountain Lakes Medical Center to use and disclose protected health information (PHI) and medication history about me to carry out treatment, payment and health care options (TPO).

The notice of Privacy Practices provided by Mountain Lakes Medical Center describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mountain Lakes Medical Center reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to Mountain Lakes Medical Center at 100 Route 46, Building B, Suite 204, Mountain Lakes, NJ 07046.

With this consent Mountain Lakes Medical Center may call my home or other alternative locations and leave a message on voicemail 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 test results among others.

I have the right to request that Mountain Lakes medical Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions but if it does it is bound by this agreement.

By signing this form I am consenting to allow Mountain Lakes Medical Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mountain Lakes Medical Center may decline treatment to me.

Mountain Lakes Medical Center has my consent to release my PHI information (including but not limited to treatment, financial statement and appointments) to _____

I acknowledge that I have been given the opportunity to review MLMC's copy of the Notice of Privacy Practices.

_____ _____ _____

Signature of Patient or Legal Guardian Date Print Name of Patient or Legal Guardian