AFFILIATED MEDICAL ASSOCIATES OF MORRISTOWN

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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 healthcare operations, it may become necessary to disclose my protected health information (PHI) to another entity, and consent to such disclosure for those permitted uses, including disclosures via fax.

I authorize Affiliated Medical Associates of Morristown, P.A. to appeal healthcare claims on my behalf.

I fully understand and accept the terms of this consent.

_____

Patient's Signature (or parent or guardian if patient is a minor)

_____

Date

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

_____

_____

[ ] Do not leave medical information on an answering machine or voicemail at home.
[ ] Do not leave medical information on an answering machine, voicemail, or with persons other than myself at my place of employment.

FOR OFFICE USE ONLY

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