SOUTH PLAINFIELD PRIMARY CARE

ALOK GOYAL, M.D. ALAMJIT GILL, M.D. MADHU GOYAL, M.D.

NAME (NOMBRE) _____SEX: M _ F ___

ADDRESS (CUIDAD) _____

CITY _____ ZIP _____ TELEPHONE _____

E-MAIL _____

DATE OF BIRTH (FECHA DE NACIMENTO) _____ ____ SS# _____

INSURANCE (SEGURA) _____ I.D. _____

REFERRING DOCTOR IF ANY _____

CONSENT TO RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize South Plainfield Primary Care to use and/or disclose my health information which specifically identifies me or which can be reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, South Plainfield Care can refuse to treat me.

I have been informed that South Plainfield Primary care has prepared a notice ("Notice") which more fully describes the uses and disclosure that cam be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have a right to review such Notice.

I understand that I may revoke this consent at any time by notifying South Plainfield Primary Care in writing. But if I revoke my consent, such revocation will not affect any action that South Plainfield Primary Care took before receiving my revocation.

I understand that South Plainfield Primary Care has reserved the right to change their privacy practice and I can obtain such changed notice upon request.

I understand that I have the right to request that South Plainfield Primary Care restrict how my individually identifiable health information is used and/or disclosed to caryy out treatment, payment and health care operation. I understand that South Plainfield Primary care must adhere to such restrictions.

Photocopy of this authorization shall be considered as effective as original.

SIGNATURE _____ DATE:_____