Patient Acknowledgement and Consent for Use and Disclosure of Protected Health information

Basic patient details

First name Last name

Birthdate

Day | Month | Year

I acknowledge receipt of a Notice of Privacy Practices from Ocean Heart Group.

With my consent, Ocean Heart Group may use and disclose protected health information about me to provide treatment, for payment or healthcare operations. The complete information can be found in the accompanied Ocean Heart Group Notice of Privacy Practices.

With my consent, Ocean Heart Group may call my home or other chosen location and leave a message on voicemail or with a designated person in reference to any items that assist the practice carrying out the provision of treatment, for payment or healthcare operations.

For example, this would pertain to appointment confirmations and obtaining payment for care provided and may be related to my clinical care, including laboratory and test results.

With my consent, Ocean Heart Group can mail to my home or other designated location any items that assist the practice in carrying out my medical care, payment or healthcare operations, such as appointment reminders and patient statements.

In accordance with Federal and HIPAA regulations, I hereby give my consent for Ocean Heart Group to release PHI about me to the following person(s):

First name | Last name | Relationship

First name | Second name | Relationship

First name | Second name | Relationship

First name | Second name | Relationship

☐ I do not with to have any of my health-related information released to anyone other than myself.

I have a right to review the Notice of Privacy Practices prior to signing this consent. I may revoke my consent in writing, except to the extent that the practice already made disclosures regarding me based on my prior consent. I understand in order to revoke my consent, I must do so in writing and send a written request via USPS Certified Mail Return Receipt to Ocean Heart Group oﬀice, at 1530 Route 88 West, Brick, NJ 08724, and I agree to allow a period of 30 days for such request to be processed by Ocean Heart Group. This Authorization for Consent shall not expire unless a written request is received at our Ocean Heart Group Oﬀice as described herein.

Signature of Patient or Legal Representative

Date

☐ I agree with the above conditions