PRINCETON MEDICAL GROUP PA

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS AND PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

1. I understand that as part of my health care, Princeton Medical Group, P.A. originates, records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Princeton Medical Group, P.A. for treatment, payment, and health care operations. For example, my health information serves as:
   - A basis for planning my care and treatment;
   - A means of communication among the many health professionals who contribute to my care;
   - A source of information for applying my diagnosis and surgical information to my bill;
   - A means by which a third-party payor can verify that services billed were actually provided; and
   - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Princeton Medical Group, P.A.'s Notice of Privacy Practices that provides a more complete description of the potential uses and disclosures of my health information. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Princeton Medical Group, P.A. reserves the right to change its Notice of Privacy Practices and will mail a copy of any revised notice to the address I have provided, prior to implementation of material changes to the Notice of Privacy.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Princeton Medical Group, P.A. is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

4. I understand that I may revoke this consent in writing, except to the extent that Princeton Medical Group, P.A. has already taken action in reliance on this consent.

5. By signing this form, I consent to Princeton Medical Group, P.A.'s use and disclosure of my health information for treatment, payment, and health care operations.

6. By signing this form, I acknowledge that I have been provided with Princeton Medical Group, P.A.'s Notice of Privacy Practices.

_____
Name of Patient

_____ ____/____/____
Signature of Patient Date

OR

_____
Name of Patient Representative and Relationship or Legal Representative (Print)

_____ ____/____/____
Signature of Patient Representative or Legal Representative Date

_____ ____/____/____
Signature of Witness Date