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CONSENT OF DISCLOSURE

(FOR THE USAGE AND/OR DISCLOSURE OF "PHI": PROTECTED HEALTH INFORMATION)

I HERBY GIVE CONSENT TO CARDIOLOGY ASSOCIATES OF MORRISTOWN AND ALL HEALTHCARE PROVIDERS FURNISHING CARE WITHIN CAM TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

YOU MY CANCEL THIS CONSENT AT ANY TIME. YOUR CANCELLATION MUST BE IN WRITING, SIGNED BY YOU OR ON YOUR BEHALF, AND DELIVERED TO THE ADDRESS AT THE TOP OF THIS FORM. THIS MAY BE DELIVERED IN PERSON OR BY MAIL, BUT IT WILL ONLY BE EFFECTIVE WHEN WE ACTUALLY RECEIVE IT. YOUR CANCELLATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT WE OR OTHERS HAVE ACTED IN RELIANCE UPON THIS CONSENT.

YOU HAVE THE RIGHT TO REQUEST RESTRICTION ON THE USAGE AND DISCLOSURE OF YOU PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. WE ARE NOT REQUIRED TO GRANT YOUR REQUEST, HOWEVER, IF WE DO, THE RESTRICTION WILL BE OBLIGATORY TO US.

OUR POSTED PRIVACY POLICY PROVIDES MORE DETAILED INFORMATION ABOUT THE USAGE AND DISCLOSURE OF YOU PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVIEW OUR POSTED PRIVACY POLICY BEFORE YOU SIGN THIS CONSENT.

WE RESERVE THE RIGHT TO AMEND THE TERMS OF OUR POSTED PRIVACY POLICY. YOU MAY OBTAIN A COPY OF THE CURRENT POLICY BY CALLING OUR OFFICE AT THE NUMBER AT THE TOP OF THIS PAGE WITH A VERBAL REQUEST, OR BY COMMUNICATING YOUR REQUEST IN WRITING TO THE ADDRESS AT THE TOP OF THIS PAGE.

PLEASE COMPLETE:

- CAN OUR OFFICE STAFF LEAVE APPOINTMENT REMINDERS, CONFIRMATIONS, AND NORMAL TEST RESULTS ON YOUR ANSWERING MACHINE AT HOME **YES NO** WORK **YES NO** CELL **YES NO**
- NAMES OF RELATIVES/FRIENDS WITH WHOM WE MAY COMMUNICATE REGARDING YOUR HEALTH STATUS/INFORMATION: _____
  _____
  KINDLY NOTE: OUR STAFF WILL NOT SHARE ANY INFORMATION REGARDING YOUR HEALTH STATUS WITH ANYONE **NOT** LISTED ABOVE. IF THIS INFORMATION CHANGES, PLEASE NOTIFY OUR OFFICE.

NAME OF PATIENT: _____OR PATIENT REPRESENTATIVE: _____
SIGNATURE: _____DATE: _____
RELATIONSHIP TO PATIENT (IF NOT SELF): _____

CANCELLATION

I HERBY VOID THE CONSENT GIVEN ABOVE.

NAME OF PATIENT: _____OR PATIENT REPRESENTATIVE: _____