PATIENT CONSENT FOR USE AND DISCLOSURE
OF
PROTECTED HEALTH INFORMATION

With my consent, ***Robert J. Maro, M.D., P.A.*** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Robert J. Maro, M.D., P.A.*** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review your Notice of Privacy Practices prior to signing this consent. ***Robert J. Maro, M.D., P.A.*** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our privacy Officer at ***27 Covered Bridge Road Cherry Hill, NJ 08034.***

With my consent, Staff of ***Robert J. Maro, M.D., P.A.*** may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others.

With my consent, Staff of ***Robert J. Maro, M.D., P.A.*** may mail to my _____ home or _____ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Staff of ***Robert J. Maro, M.D., P.A.*** may e-mail to my _____ home or _____ office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that ***Robert J. Maro, M.D., P.A.*** restrict how ***The Staff*** uses or discloses my PHI to carry out TPO. However, ***Robert J. Maro, M.D., P.A.*** is not required to agree to my requested restrictions, but if ***Robert J. Maro, M.D., P.A.*** does, they are bound by our agreement.

By signing this form, I am consenting to ***Robert J. Maro, M.D., P.A.*** use and disclosure of my PHI to carry out TPO. This consent may be revoked in writing except to the extent that ***Robert J. Maro, M.D., P.A.*** has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, ***Robert J. Maro, M.D., P.A.*** may decline to provide treatment to me.

_____ _____
Signature of Patient of Legal Guardian Print Patient Name

_____ _____
Print Name of Patient or legal Guardian Date

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY RULES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read if I so choose and understood the Notice.

Patient Name: _____ Date: _____
(Please Print)

Parent or Authorized Representative: _____

Signature: _____