

EDGEWATER PEDIATRICS, P.C.
115 RIVER ROAD
SUITE 1003
EDGEWATER, NJ 07020

TEL: (201) 945-9453
FAX: (201) 945-9484
DR. SUSHMA D. KAUL, M.D.

PATIENT/GUARANTOR CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent form. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICE**

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by Edgewater Pediatrics, P. C.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operation. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient

Signature of Guarantor/Parent

Date Received