ANDREW L. SIMON, M. D., F. A. C. S., P. A.

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Andrew L. Simon M. D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (**Andrew L. Simon, M.D.'s** Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Andrew L. Simon, M. D.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Andrew L. Simon, M. D., 459 Jack Martin Boulevard, Suite 3, Brick, New Jersey, 08724.**

With this consent, **Andrew L. Simon, M. D.** may:

1. Call my home or other alternative location 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 calls pertaining to my clinical care, including laboratory results, among others.
2. Mail to my home, or other alternative location, 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.
3. E-mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment or patient reminder cards, patient statements and access to patient portal. I have the right to request that **Andrew L. Simon, M. D.** restrict how it uses, or discloses, my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Andrew L. Simon, M. D.** the use and disclosure of my PHI to carry out TPO.

I may revoke my consent, in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Andrew L. Simon, M.D.** may decline to provide treatment to me.

Patient Name (or Legal Guardian): ___________________________ Date: _________________________

Signature of Patient (or Legal Guardian): ____

ANDREW L. SIMON, M. D., F. A. C. S.

Permission to release Medical Information

I, _______________________________________ hereby acknowledge that I have received a Notice of Privacy Practice from **Andrew L. Simon, M. D**. and designate the persons listed below, as authorized contacts to speak with and or, release information to:

Name / Relationship / Phone Number ____

Name / Relationship / Phone Number ____

Name / Relationship / Phone Number ____

Patient Signature: ____