PERINATAL ASSOCIATES LLC
363 Boulevard Suite 1R Passaic NJ 07055
PATIENT CONSENT FORM
For Release of Protected Health Information (PHI)

General Information

As a patient of Perinatal Associates LLC (PALLC) when you seek medical advice or receive medical care information (past, present, and future) and personal information such as your name, address and social security number. This information will be used for the treatment of your medical condition (s), obtaining payment from your insurance company and for Healthcare Operations within PALLC.

Notice of Privacy Practices

For a description of how your Protected Health Information (PHI) may be used and disclosed, please review PALLC's "Notice of Privacy Practices" prior to signing this consent. A copy of the notice is available at the reception desk and at check-out. You may keep a copy for your records. PALLC reserves the right to change the notice and will notify all patients of such changes prior to the effective date.

Patient Rights

You have the right to restrict the uses and disclosures of your PHI for the purpose of your treatment, payment for your services and the healthcare operations of PALLC, however we are not required to agree to requested restrictions but we are bound by any restrictions agreed upon.

Permission to release Your Protected health Care Information to Family Members or Others

→ Please mark whether or not you choose to authorize us to release medical and/or insurance information to family or others:___No___Yes (If yes, please indicate the individual name(s) below.)

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

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PALLC has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Your signature below acknowledges:

- You have read and understand this consent.
- You agree to authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician seeing you.
- You agree to have the PHI used and disclosed by PALLC for the purpose of your treatment, to secure payment for your treatment and for PALLC healthcare operations.
- Prior to signing this consent, you were given the opportunity to review PALLC's "Notice of Privacy Practices."
- You are permitting the release of your PHI to the persons noted above.
- You are aware that you may now or at any time request restrictions to the use and disclosure of your PHI.

Printed Patient Name	Date of Birth
Signature of Patient or Patient's Representative (If Representative signs include legal document and print name below)	Date Signed