



**MEADOWBLOOM
CENTER FOR
PEDIATRIC NEUROLOGY**

Shivani Shah, DO, MPH

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

For Treatment, Payment, or Healthcare Operations — New Jersey

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: _____

Today's Date: _____

Medical Record #: _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of, and/or have received, this practice's Notice of Privacy Practices, which describes how my (or my child's) protected health information (PHI) may be used and disclosed, and how I can access this information.

- ☐ I have received a copy of the Notice of Privacy Practices
- ☐ I was offered a copy but declined
- ☐ I acknowledge the Notice is available upon request and posted at the practice /on its website

CONSENT FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I voluntarily consent to allow Meadowbloom Center for Pediatric Neurology and its healthcare providers, employees, and business associates to use and disclose my (or my minor child's) protected health information for purposes of:

- ☐ Treatment — coordinating and providing medical care, including sharing information with other treating providers, specialists, hospitals, laboratories, and imaging centers
- ☐ Payment — billing and collecting payment from insurance carriers, government payors, or other responsible parties
- ☐ Healthcare Operations — quality assessment, care coordination, staff training, accreditation, and other routine administrative and business functions

I understand that federal law (HIPAA, 45 C.F.R. § 164.506) does not require this consent for the practice to use or disclose health information for treatment, payment, or healthcare operations, and that this consent is being obtained as a matter of practice policy and to document my understanding of these routine uses.

CONSENT ON BEHALF OF A MINOR PATIENT

If the patient is a minor, this consent is provided by the parent or legal guardian as the minor's personal representative. I understand that under New Jersey law, minors of a certain age (for example, age 16 and older for certain outpatient behavioral health services) may have an independent right to consent to and control disclosure of specific categories of treatment records, and that this general consent does not override those independent rights where they apply.

Parent/Guardian Name: _____

Relationship to Patient: _____

RIGHT TO REVOKE OR RESTRICT



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1. I understand that I may revoke this consent at any time by submitting a request in writing, except to the extent the practice has already relied on this consent to use or disclose information.
2. I understand I have the right to request restrictions on how my health information is used or disclosed for treatment, payment, or healthcare operations, and that the practice is not required to agree to such restrictions except as required by law.
3. I understand that this consent will remain in effect until revoked in writing and does not have an expiration date unless otherwise required by law.

SIGNATURE

Signature of Patient/Legal Guardian: _____

Date: _____

Print Name: _____

Relationship to Patient: _____

— For Office Use Only —

Received by: _____

Date: _____
