

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

With my consent, Lawrenceville Neurology Center, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lawrenceville Neurology Center's P.A. Notice of privacy practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lawrenceville Neurology Center, P.A. reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office at 3131 Princeton Pike Bldg. 3C Suite 2021, Lawrenceville, NJ 08648.

With my consent, Lawrenceville Neurology Center, P.A. may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

**I wish to be contacted in the following manner (check all that applies):**

- Home Telephone \_\_\_\_\_
  - O.K. to leave a message with detailed information
  - Leave a message with name of practice and call back number only.
  
- Work Telephone \_\_\_\_\_
  - O.K. to leave a message with detailed information.
  - Leave message with name of practice and a call back number only.

**I grant permission for you to discuss my care with the following person(s)**

Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____

By signing this form, I am consenting to Lawrenceville Neurology Center's, P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lawrenceville Neurology Center, P.A. may decline to provide treatment to me.

***\*Each dated signature is valid for one (1) year\*\****

\_\_\_\_\_  
PRINT NAME OF PATIENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

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SIGNATURE OF PATIENT/LEGAL GUARDIAN

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