Dr. Ahdi Elias and Dr. Salwa Elias
2839 Route 10 East, Suite 202
Morris Plains, NJ 07950
Internal Medicine
Allergy, Asthma, Immunology & Respiratory Disease Center

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPA)

Section A: ***Patient giving consent***

Name: _____
(Please Print)

Address: _____

Telephone #: _____ Cell Phone #: _____

E-Mail: _____ SS #: _____

Section B: ***To the Patient – Please Read the Following Statements Carefully***

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions to our Notice, at any time by contacting:
Dr. Ahdi Elias or Dr. Salwa Elias at 2839 Route 10 East, Suite 202 Morris Plains, NJ 07950 (973) 292-9248/(973) 292-9247 fax

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I _____ **have had full opportunity to read and consider the contents of this Consent form and your**
Printed Name
Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X _____ X _____

Signature **Date**

If this Consent is signed by a personal representative (i.e. parent/guardian), on behalf of the patient, please complete the following:

Personal Representative filling out this form : _____

_____

Address **City** **State** **Zip**

_____

Representative Phone # **Cell Phone #**

Relationship to Patient: _____

This original Consent shall be included in patient chart.
You are entitled to a copy of this consent after you sign it.

(Please turn over for Acknowledgment of Receipt of Notice of Privacy Practices)

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices for:

Dr. Ahdi and/or Dr. Salwa Elias

Signature of Patient: X_____

Date:_____

***If person signing is not the patient, please print your name and relationship to the patient**

Printed name of person signing above:_____

Relationship to patient:_____

I (the patient or representative), request a copy of the Notice of Privacy Practices: Yes_____No_____

For Office Use:

If patient/representative requested a copy of Notice, date copy was provided:_____

If no acknowledgement could be obtained, state the reasons why, and the efforts taken to try to obtain the acknowledgement:_____

_____

Revocation of Consent:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

*Signature:*_____ *Date:*_____