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Patient acknowledgement and consent for use and disclosure of protected health information

I, the undersigned, acknowledge receipt of the currently effective Notice of Privacy Practices. This consent for use and disclosure of Privacy Practices. I have the right to review the Notice of Privacy Practices effective 01/01/2018 prior to signing this consent. VRMNJ reserves the right to revise its notice of Private Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to VRMNJ. With this consent VRMNJ may call my home and 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 clinical care, including laboratory test results among others.

I hereby give my consent for VRMNJ to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Additionally, my information may be used to determine if I am a candidate for any research studies being conducted at VRMNJ under the supervision of Vatsal Doshi, MD and or Dr. Boleslav Kotlyar. The Notice of Privacy Practices provided by VRMNJ describes such uses and disclosure more completely.

With this consent VRMNJ may mail to my home or other alternative location any items to assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential”, as well as the use of my email address to contact me in regards to changes in business hours, appointment information and introduction of new services provided by the Practice.

I have the right to request that VRMNJ restrict how it uses or discloses my PHI to carry out TPO for which I must submit my written request to the HIPAA compliance officer at VRMNJ.

By signing this form, I am consenting to VRMNJ and Vatsal Doshi M.D and or Dr. Boleslav Kotlyar to use and disclose my PHI for research activities performed by Touchstone Clinical Research, LLC.

I may revoke my consent in writing to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign the consent, or later revoke it, VRMNJ may decline to provide treatment to me.

Signature of patient or legal guardian: ______________________________Date:_____/______/______

Print Patient’s or legal guardian’s name: ________________________________