ADVANCED CARE OB/GYN
HIPAA PRIVACY NOTICE CONSENT FORM

I understand and have been provided with Advanced Care's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. Advanced Care reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider Advanced Care's Notice of Privacy Practices prior to signing this consent and making healthcare decisions. I also understand and agree to have **my digital photo** identification taken as part of my electronic health records.

I authorize Advanced Care to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare giver.

Advanced Care maintains patient medical records on paper, on microfilm and/or electronic media which may be accessible to any physician or healthcare provider participating in my current or future care. Medical records are disclosed according to applicable NJ State and Federal laws, and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

_______ Patient ONLY **OR**

You may disclose my medical information to:

______________________	______________________	______________________
Please Print Name	Relationship	Phone Number

EMERGENCY CONTACT: MEDICAL INFO IS NOT RELEASED TO THIS PERSON. (HOWEVER, THIS PERSON CAN BE THE SAME AS YOUR HIPAA AUTHORIZED CONTACT.)

______________________	______________________	______________________
Emergency Contact	Relationship	Phone Number

I acknowledge that I have received a copy of Advanced Care's Notice of Privacy Practices.

____________________________________	______________________
Signature of patient of legal guardian	Date