1944 CORLIES AVENUE
SUITE 206
NEPTUNE, NJ 07753
P 732-774-8282
F 732-774-4407

MONMOUTH OCEAN NEUROLOGY

BOARD CERTIFIED IN NEUROLOGY

OCEAN MEDICAL PARK
190 JACK MARTIN BLVD,
BLDG B3
BRICK, NJ 08724
P 732-785-1500
F 732-785-0116

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Practice's Notice of HIPPA Privacy:
I have received a copy of the Notice of HIPPA Privacy for the Physician Practice.

_____	_____	_____	_____
Name of Patient	Date of Birth	Signature of Patient/Parent/Guardian	Date

II. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care. I wish to be contacted in the following manner (check all that apply):

Telephone, Written and Fax Communication

Home Telephone Number:
_____
__ Ok to leave message with detailed information
__ Leave message with call back numbers only

Work Telephone Number:
_____
__ Ok to leave message with detailed information
__ Leave message with call back numbers only

Written Communication:

__ Ok to mail to my home address
__ Ok to mail to my work/office address

Fax Communication:

__ Ok to fax to this number

Other:_____

B. I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ Last four digits of his/her SS Number (required):_____

Print Name:_____ Last four digits of his/her SS Number (required):_____

Print Name:_____ Last four digits of his/her SS Number (required):_____

C. The following person(s) are not authorized to receive my Patient Health Information:

Print Name: _____ Print Name:_____

_____	_____
Signature of Patient/Parent/Guardian	Date

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Notice of Privacy Policy Practices Acknowledgement and Consent

Monmouth-Ocean Neurology, P.C.

By signing below, I acknowledge that I have been provided a copy of the Monmouth-Ocean Neurology, P.C. Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for the services given to me, and for the business operations of the medical group, its staff, and its business associates.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority