CONSENT TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I__________________________________of__________________________________

Patient's Name Address

give "Ocean Pulmonary Associates, PA" my consent to use and disclose any and all protected health information created by Ocean Pulmonary Associates, PA and/or maintained in my "medical record" (including all medical reports, diagnosis, clinical abstracts, case histories, proposed treatment plans and prognosis, x-ray reports, insurance information and/or any other information) as necessary to carry out treatment, payment or health care operations.

I understand that a complete description of the uses and disclosures that may be made of my health information are set forth in Ocean Pulmonary Associates, PA Notice of Privacy Practices. I understand that I have a right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices is subject to change, and that if there is a change, Ocean Pulmonary Associates, PA will provide me with a revised copy.

I understand that Ocean Pulmonary Associates, PA may refuse to provide treatment to me if I do not execute this consent. I further understand that I have the right to request that Ocean Pulmonary Associates, PA restrict how my medical record is used or disclosed to carry out treatment, payment, or health care operations. However, Ocean Pulmonary Associates, PA is not required to agree to my requested restrictions. If Ocean Pulmonary Associates, PA does agree to my requested restrictions, such restrictions will be binding to the group.

I understand that the specific information released may contain information in reference to alcohol/drug abuse, sexually transmitted diseases, HIV/AIDS infection and/or psychiatric conditions and the treatment of these disorders. However, I understand that an additional authorization will be required in most cases before Ocean Pulmonary Associates, PA may use or disclose any psychotherapy notes.

I understand that the terms of this consent are governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its implementing regulations. I understand that I have the right to revoke this consent, at any time, except to the extent that Ocean Pulmonary Associates, has taken action in reliance thereon. I understand that any revocation must include my name, address, telephone number, date of this consent, and my signature and that I should send it to:

Ocean Pulmonary Associates, PA
20 Hospital Drive
Suite 9
Toms River, NJ 08755

____________________________________ ____________________

Signature Date of Consent