Alexander Shifrin Medical, P.C.
the address every woman should know
Obstetrics & Gynecology

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Alexander Shifrin Medical P.C. may use and disclose protected health information about me to carry out treatment and conduct payment and health care operations. Please refer to Alexander Shifrin Medical P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. It is available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Alexander Shifrin Medical P.C. reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Alexander Shifrin Medical P.C. at 121 East 60th Street, Suite 1D, New York, NY, 10022.

With my consent, Alexander Shifrin Medical P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment and to conduct payment and healthcare operations such as appointment reminders, insurance terms, and any call pertaining to my clinical care including laboratory results among others.

With my consent, Alexander Shifrin Medical P.C. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that Alexander Shifrin Medical P.C. restrict how he uses or discloses my Protected Health Information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this form I am consenting to Alexander Shifrin Medical P.C.'s use and disclosure of my Protected Health Information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior agreement. If I do not sign this consent, Alexander Shifrin Medical P.C. may decline treatment to me.

_____ _____

Signature of PATIENT or Legal Guardian Date

_____

Print PATIENT Name or Legal Guardian Name

121 E 60th St., Suite 1D, New York, NY 10022 Tel: 212-534-4707 Fax: 212-537-0647 www.doctorshifrin.com
9920 4th Ave., Suite 210 Brooklyn, NY 11209 Tel: 718-238-4707 Fax: 718-238-4706 info@doctorshifrin.com