



CONSENT FOR RELEASE OF INFORMATION FOR EVALUATION, TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, hereby authorize Garden State Hand Therapy, Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Garden State Hand Therapy, Inc. can refuse to treat me.

I have been informed that Garden State Hand Therapy, Inc. has prepared a notice, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Garden State Hand Therapy, Inc. in writing, but if I revoke my consent, such revocation will not affect any actions that Garden State Hand Therapy, Inc. took before my written revoke notice. I understand that Garden State Hand Therapy, Inc. reserves the right to change privacy practices and that I can obtain such notice upon request.

I understand that I have the right to request that Garden State Hand Therapy, Inc. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations, I understand that Garden State Hand Therapy, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, Garden State Hand Therapy, Inc. must adhere to such restrictions.

X

Signature of Patient or Patient's representative

Date

X

Printed Name of Patient or Patient's representative

X

Relationship to the Patient