Skylands Medical Group, P.A.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Account#: ____________________

Patient Name: ______________________ ______________________ ______________________
Last First Middle

Address: ____

City: ______________________ State: ______ Zip Code: __________

Home Phone #: ______________________ Birth Date: ______________________

With my consent, Skylands Medical Group, P.A. and covered entities including Inspiration MedSpa (SMG and Entities) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the SMG and Entities Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SMG and Entities reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Skylands Medical Group, P.A. Privacy Officer, 33 Newton-Sparta Road, Suite 6, Newton, NJ 07860.

With my consent, SMG and Entities may call, e-mail, or mail to my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SMG and Entities may call, e-mail, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and to receive free health resources and periodic special offers from our offices.

By signing this form, I am consenting to SMG and Entities' use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SMG and Entities may decline to provide treatment to me.

Is there a person that you authorize to receive/discuss your PHI? ☐ Yes ☐ No

If yes, please indicate name and relationship: ______________________

Special Instructions: ______________________

______________________ Date: ______________________
Patient's Name (print)

______________________ ______________________
Parent/Legal Guardian Name (print) Signature of Patient or Legal Guardian