Joshua Shifrin, PhD, ABSNP, NCSP

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Patient Consent for Use and Disclosure
of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for Dr. Shifrin to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices--- Updated 9/23/13 provided by Dr. Shifrin describes such uses and disclosures more completely.) Any uses or disclosures of personal information not described in this Privacy Notice require a signed Authorization before PHI can be released. We are required to provide notification if there is a breach of insecure PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Dr. Shifrin reserves the right to revise its Notice of Privacy Practices at any time. An up-to-date Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Shifrin (860) 966-0309.

With this consent, Dr. Shifrin may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, Dr. Shifrin may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, treatment availability and patient billing statements and medical records.

With this consent, Dr. Shifrin may e---mail to my home or other alternative location any items that assist the practice in carrying out TPO, , such as appointment reminder cards, treatment availability and patient billing statements and medical records. I have the right to request that Dr. Shifrin restrict how he uses or discloses my PHI to carry out TPO. 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 allow Dr. Shifrin to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Shifrin may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable