

CHERYL ACKERMAN, M.D., P.C.  
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**Patient consent for use and Disclosure of Protected Health Information**

**Privacy Policy**

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The notice contains a "Patient Rights" section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of our notice may change. If we change your notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**Consent to Release Information**

By signing this form, you permit the practice to release any medical information to the physicians involved in my care. You consent that the practice may call my house or other designated locations and leave a message on voice mail or in person, in reference to appointment reminders and insurance items. In addition, the practice may mail to my home appointment reminders and patient statements.

I designate the following representative(s) for the provider to communicate with on my behalf. If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

**Signature on File**

I request that payment of authorized benefits be made on my behalf to Cheryl D. Ackerman, M.D. for services furnished to me. I authorize any holder of medical information about me to release to Empire Medicare Services or any other of my medical carriers any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

Signature of Patient or Legal Guardian \_\_\_\_\_

Print Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Print Legal Guardian Name \_\_\_\_\_