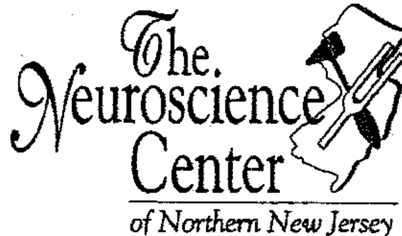
*Kenneth R. Cerny, MD**
*Mark S. Diamond, MD**
*Stuart W. Fox, MD**
*Richard S. Rosenberg, MD**
*Matthew F. Conigliari, MD**
*Oladontun A. Okunola, MD**
* Diplomate American Board of Psychiatry & Neurology



310 MADISON AVENUE
MORRISTOWN, NJ 07960
Tel: 973-285-1446 Fax: 973-605-8854

CONSENT TO THE USE, AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my treatment, this facility originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment I understand that this information serves as:

- Basis for planning my care and treatment
- A means of communication among any other health care professionals who might contribute to my care, for example via facsimile, telephone, etc.
- A source of information for applying my diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed are accurate and actual.
- And as a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare officials.

I understand this practice will take great care to insure that any and all information pertaining to me, and my treatment here will be handled with an emphasis on, maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required to agree to these restrictions, in the event of an emergency. I understand that I may revoke this consent in writing, at any time.

____
Print Name of Patient, or Legal Guardian

I have read, understand, and accept the terms of this consent to the above use of my Personal Health Information (PHI).

____
Signature of Patient, or Legal Guardian Date