



Allied Orthotics & Prosthetics

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Patient Consent for Purposes of Treatment, Payment and Healthcare Operations

By signing this form, I consent to the use or disclosure of my protected health information by **ALLIED ORTHOTICS AND PROSTHETICS** for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct **ALLIED ORTHOTICS AND PROSTHETICS'** health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that **ALLIED ORTHOTICS AND PROSTHETICS** has taken action in reliance on my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by **ALLIED ORTHOTICS AND PROSTHETICS**, and that relates to my past, present or future physical or mental health or condition.

I understand i have a right to review **ALLIED ORTHOTICS AND PROSTHETICS'** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of our health care operations. The Notice of Privacy Practices also describes my rights and **ALLIED ORTHOTICS AND PROSTHETICS'** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the **MAIN PATIENT WAITING AREA** and on **ALLIED ORTHOTICS AND PROSTHETICS'** website at www.alliedoandp.com.

As noted in ALLIED ORTHOTICS AND PROSTHETICS' Notice, ALLIED ORTHOTICS AND PROSTHETICS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing **ALLIED ORTHOTICS AND PROSTHETICS'** website.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or our healthcare operations. **ALLIED ORTHOTICS AND PROSTHETICS** is not required to agree to the restrictions that I may request, but if it does, it is bound by its agreement.

I understand that diagnosis or treatment of me by **ALLIED ORTHOTICS AND PROSTHETICS** may be conditioned upon my consent as evidenced by my signature on this document.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority