Andrea Nomberg MD

Patient Consent for use an Disclosere of Protected Health Information

With my consent, Andrea Nomberg MD, may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operation(TPO). Please refer to Andrea Nomberg's notice of Privacy pratices for a more complete description of such use and disclosures which can be found in the waiting room. A copy for you can be made at anytime. I have the right to review the notice of privacy practices prior to signing this consent. Andrea Nomberg, Reseves 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 Andrea Nomberg, MD. Privacy officer at 709 Hawkins Ave, Ronkonkoma,NY 11779

With my consent, Andrea Nomberg,MD. may call home or other designated locations 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 laboratory and radiology results, among others. Normal lab values and non-sensitive information may be left with immediate family members or on your voicemail. However, we will make every attempt to discuss abnormal results and sensitive information only with you, the patient. As always, you are welcome to contact us at anytime in reference to any aspect of your care. You must noitfy us in writing if you do not want your care discussed with anyone but you, the patient. We will abide by that request except in a emergency situation in which your life or health are threatened. With my consent, Andrea Nomberg,MD. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statement as long as they are marked personal and confidential. Birthday and sympathy cards may be sent, However with out being marked confidential.

With my consent, Andrea Nomberg, MD. may email to my home or other designated location with any items that assist the practice in carrying

out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Andrea Nomberg, MD. restrict how it uses or discloses my PHI to carry out TPO.

However, 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 Andrea Nomberg,MD. use and disclosure of my PHI to carry out TPO.

Disclosures rely upon my prior consent. If i do not sign this consent, Andrea Nomberg, MD. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal guardian Date

_____

Print name of patient

I allow this person to pick up or call about records on my behalf.

_____

Printed name of person allowed to pick up records

_____

Signature of patient