



NOTICE OF PRIVACY PRACTICES

(For the Usage and/or Disclosure of Protected Health Information)

I hereby give consent to the Washington Township Medical Group, Inc. and all health care providers furnishing care with Washington Township Medical Group, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that others or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by: Contacting our office at **(510) 793-2880**, or visiting our web site at www.wtmg.com

Print Name of Patient: _____

Signature: _____

If you are signing as the patient’s representative:

Print Your Name: _____

Relationship: _____

CANCELLATION

I hereby void the consent given above.

Print Name of Patient: _____

Signature: _____

If you are signing as the patient’s representative:

Print Your Name: _____

Relationship: _____

Address for cancellation:

Your cancellation will be effective, upon receipt, at the following address:

Washington Township Medical Group, Inc.