Diane Hilal-Campo, MD
43 Yawpo Avenue, Suite #1
Oakland, New Jersey, 07436
(201) 337-9300

Patient HIPAA Consent

Consent for purposes of treatment, payment and healthcare operations. I consent to use this disclosure of my protected health information by Diane Hilal Campo, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Diane Hilal Campo, M.D. I understand that diagnosis or treatment by Diane Hilal Campo may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Diane Hilal Campo, M.D. is not required to agree to the restrictions that I may request. However, if Diane Hilal Campo, M.D. agrees to the restriction it is binding on the practice. I have the right to revoke this consent, in writing, at any time, except to the extent that Diane Hilal Campo, M.D. has taken action in reliance on this consent. My protected health information means health information, including my demographic information, collected from me and created by my physician, another health care provider, health plan, my employer or health care clearing house. This protected health information relates to my past, present or future physical or mental health condition as it identifies me, or there is a response basis to believe the information may identify me. I understand I have the right to review Diane Hila Campo, M.D. 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 will occur in my treatment, payment of my bills or in the performance of the health care operations of Diane Hilal Campo, M.D. Diane Hilal Campo, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Diane Hilal Campo, M.D. by calling the office and requesting a revised copy by sent to me in the mail or by asking at the time of my appointment.

Patient Signature _____Date _____

Guardian Signature (If patient is under 18 years old) _____

Access to Private Health Information, I _____ authorize the staff of Diane Hilal Campo, M.D. to release information to the following family members or friends.

_____ Relationship: _____

_____ Relationship: _____

I authorize Dian Hilal Campo, M.D. to contact me concerning health care information through:

__ Home/cell/voicemail # _____ leave a message

__ Work phone/voicemail # _____ leave a message