Total Patient Care, LLC
459 Jack Martin Blvd.
Brick NJ 08724

Acknowledgment of Receipt of Notice of Total Patient Care LLC's Notice of Privacy Practices and Consent for Use and Disclosure of Health Information

I, _____, acknowledge receipt of Total Patient Care LLC's (the "Provider") Notice of Privacy Practices dates_____ and I consent to the Provider's use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and health care operations of the Provider and in accordance with the Notice of the Provider's Privacy Practices.

I understand that while this consent is voluntary, if I refuse to sign this consent, the Provider can refuse to treat me. I also consent to the restrictions contained in the Notice of Privacy Practices regarding all workers compensation information. I understand that such information will not be disclosed to me without the written authorization of the applicable workers compensation carrier/payor. In the event that such workers compensation carrier/payor refuses to release any and all such records, I hold the Practice and all of its shareholders, physicians, employees and agents harmless in connection with such refusal.

I understand that I have the right to request that the Provider restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent at any time by notifying the Provider in writing, but if I revoke my consent, such revocation will not affect any actions that the Provider took before receiving my revocation.

_____ _____
Signature of Patient or Patient's representative Date

_____ _____
Printed Name of Patient or Patient's representative Date

_____
Relationship to the Patient