SUBURBAN PULMONARY MEDICINE, P.C.

DANIEL C. DUPONT, D.O., F.C.C.P.
ERIC S. HEFFELFINGER, D.O., F.C.C.P.
GERALD A. MEIS, D.O., F.C.C.P.
PULMONARY DISEASE
CRITICAL CARE
OCCUPATIONAL LUNG DISEASE

1 BARTOL AVENUE, SUITE 14
RIDLEY PARK, PENNSYLVANIA 19078
TELEPHONE (610) 521-1300
FAX (610) 521-9074 – E-MAIL SUBPUL@AOL.COM

196 WEST SPROUL ROAD, SUITE 210
SPRINGFIELD, PENNSYLVANIA 19064
TELEPHONE (610) 604-4400
FAX (610) 328-5931

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign this Acknowledgement

I,________________________________ have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature Date

For Office Use Only

We Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other(Please specify)

____

____

____

SUBURBAN PULMONARY MEDICINE, P.C.

DANIEL C. DUPONT, D.O., F.C.C.P.
ERIC S. HEFFELFINGER, D.O., F.C.C.P.
GERALD A. MEIS, D.O., F.C.C.P.
PULMONARY DISEASE
CRITICAL CARE
OCCUPATIONAL LUNG DISEASE

1 BARTOL AVENUE, SUITE 14
RIDLEY PARK, PENNSYLVANIA 19078
TELEPHONE (610) 521-1300
FAX (610) 521-9074 – E-MAIL SUBPUL@AOL.COM

196 WEST SPROUL ROAD, SUITE 210
SPRINGFIELD, PENNSYLVANIA 19064
TELEPHONE (610) 604-4400
FAX (610) 328-5931

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize **SUBURBAN PULMONARY MEDICINE, P.C**. to use and disclose the medical

and health information of ____________________________________for the following
(Name of Patient)
purpose(s)

- **Treatment –** includes activities performed by the physician, nurse or medical assistant, as well as coordinating or managing care provided to you with third parties, and consultations involving physicians and other health care providers.
- **Payment** – includes activities involved in determining whether you are eligible for medical plan coverage, billing matters, and reimbursement for your medical benefit claims, as well as utilization management programs addressing review of medical service for clinical necessity, appropriateness of charges, precertification and preauthorization of services.
- **Health Care Operations** – includes associated business and administrative affairs of this office.
- **Other** – (please explain)

____

____

You have the right to revoke this Consent. However, you must revoke this Consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within which this Consent is effective.

________________________ ________________________ or
Date Signature of patient

________________________ ________________________
Date Signature of guardian or Power of Attorney