

**NORTHFIELD SURGICAL CENTER, L.L.C.**  
**741 NORTHFIELD AVE., SUITE 102, WEST ORANGE, NEW JERSEY 07052**  
**973-243-1062**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**  
**(For Treatment, Payment and Health Operations)**

I \_\_\_\_\_ understand that in the course of providing care to me the  
*(print name)*  
Center will receive, create, maintain and disclose information about me for the purpose of the Center's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Center and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Center's Notice of Privacy Practices.

Except for genetic information, I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable diseases, including tuberculosis and venereal diseases, and substance abuse and/or treatment, if applicable, as is reasonably necessary by the Center, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the Center's operations. I further agree to the disclosure by the Center of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law.

This consent may be revoked at any time but, only to the extent that the Center has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the Center and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operations.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or legal representative  
(if signed by a representative, print title  
(e.g., parent/guardian, power of attorney)