

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Bruce R. Gilbert, M.D., Ph.D., PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Bruce R. Gilbert, M.D., Ph.D., PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Bruce R. Gilbert, M.D., Ph.D., PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bruce R. Gilbert, M.D., Ph.D., PC Privacy Officer at 900 Northern Blvd. Suite 230, Great Neck, NY 11021.

With this consent, Bruce R. Gilbert, M.D., Ph.D., PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. With this consent, Bruce R. Gilbert, M.D., Ph.D., PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Bruce R. Gilbert, M.D., Ph.D., PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Bruce R. Gilbert, M.D., Ph.D., PC restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to BRUCE R. GILBERT, M.D., PH.D., PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BRUCE R. GILBERT, M.D., PH.D., PC may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian



