NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt from the Offices of

Marlton Neurology
Marlton Family Medicine
Chronic Pain Specialists

562-B Lippincott Dr. Marlton, NJ 08053
Phone: 856 890 0903 **Fax:** 856 890 0904

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I am in receipt of "Notice of Privacy Practices" (effective date August 1, 2026) from the offices of **Marlton Neurology, Marlton Family Medicine and Chronic Pain Specialists.**

I understand that my protected health information may be used or disclosed to carry out treatment, payment and health care operations as detailed in the "Notice of Privacy Practices". I understand that the practices of **Marlton Neurology, Marlton Family Medicine and Chronic Pain Specialists** have the right to change the notice and that if this occurs, I can obtain a revised copy in the office.

I understand that I have the right to request that the practice further restrict how the protected health information is used or disclosed to carry out treatment, payment, or health care operations and that the practice is not required to agree to such requested restrictions. If the practice agrees to the requested restriction, this agreement is binding. I understand that I have the right to revoke the consent in writing except to the extent that the practice has taken actions in reliance on the previously signed consent.

Patient/Representative Signature _____ Date _____

Patient/Representative Name _____ Date _____

Witness (Signature/Name) _____ Date _____