CENTRAL JERSEY REHABILITATION MEDICINE, L.L.C.

CONSENT, DISCLOSURE AND AUTHORIZATION FORM

<table>
<tr><td colspan="2">Patient Name</td><td>Date of Birth</td><td>Medical Record #</td></tr>
<tr><td colspan="4">Address</td></tr>
<tr><td colspan="2">Home Telephone:</td><td colspan="2">Work Telephone:</td></tr>
<tr><td>Cell Phone Number:</td><td colspan="3">Email Address:</td></tr>
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If you provide your cell phone number and email address above, you are authorizing us to text message you on your cell number and to email you at the your email address relating to your care at our office.

As used in this form below, the words “I,” “me,” “my” and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize **Central Jersey Rehabilitation Medicine, L.L.C.** (“CJRM”) and all physicians, physician assistants, nurses, and other ancillary medical personnel of CJRM, to perform medical examinations and provide routine care for all my visits to CJRM. This may include routine rehabilitation services, diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of CJRM, as further described below. Any photographs or other images taken will become part of my medical record. CJRM will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures may require a specific informed consent, and that CJRM will provide me with information and forms prior to such procedures.

Acknowledgment of Policy on Narcotic Drug Prescribing

I acknowledge that narcotic and other controlled drugs are not routinely prescribed by CJRM, and that exceptions will be made only on a case-by-case basis and in the sole discretion of my CJRM.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize CJRM to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health

care operations of CJRM. I understand that, for example, my health information may be used or disclosed by CJRM to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by CJRM; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand CJRM may release my protected health information as required by law or court order. Further information is contained in CJRM's Notice of Privacy Practices.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the CJRM Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that CJRM has the right to change its Notice of Privacy Practices from time to time and that whenever an important change is made, CJRM will post a new notice in the office. I may contact CJRM at any time to obtain a copy of the Notice of Privacy Practices. I also may access a copy on CJRM's website.

Disclosures to Authorized Individuals

I understand that CJRM may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care, to whom information about me may be disclosed and discussed:

Name:	Relationship:
Home Telephone:	Cell Phone Number:

Name:	Relationship:
Home Telephone:	Cell Phone Number:

Emergency Contact

In case of an emergency, please contact the below individual. You may provide general information about me, including as necessary to communicate information about the emergency.

Name:	Relationship:
Home Telephone:	Cell Phone Number:

Medical Record Charges

CJRM may charge a reasonable, cost-based fee for copies of medical records, in accordance with the requirements of HIPAA, as follows:

$6.50 for paper copies, inclusive of postage if mailed.

$6.50 for a copy in electronic format (e.g., memory stick or flash drive or encrypted email), inclusive of postage if mailed.

If you desire a written explanation or summary of your health record information, we will charge a reasonable fee that will be discussed with you in advance and upon your approval.

CJRM will not charge you to access to your clinical notes in CJRM's electronic health record, in accordance with the 21st Century Cures Act "open notes" requirements and other applicable laws or regulations.

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document.

Patient Name ______________________________ Date ____________________

Patient Signature ____

Authorized Individual (Parent/Guardian) Name __________________________

Authorized Individual Signature ____________________________________

Basis of Authority (e.g., parent, guardian): ___________________________

(Authorized individuals will be required to provide proof of authority.)