

**CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

The Patient hereby consents to the use or disclosure of her individually identifiable health information (“protected health information”) by Professional Women’s Healthcare, P.A. (“Facility”) in order to carry out treatment, payment or healthcare operations. The Patient should review the Facility’s Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice upon request.

Patient retains the right to request that the Facility further restrict how her protected health information is used or disclosed to carry out treatment, payment or healthcare operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient’s requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat Patient if she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Signature of Patient

Please print name

Signature of witness

Person signing on behalf of Patient*

Please print name

* Please explain Representative’s relationship to Patient and include a description of Representative’s authority to act on behalf of the Patient:

**Authorization for Release of Medical Records
(OPTIONAL)**

(Print Patient's Full Name)

(Date of Birth)

(Address)

(Social Security #)

(City, State, Zip code)

(Home Phone)

At my request, I _____ do hereby authorize Professional Women's
Healthcare, PA to release the following information checked off below:

ALL Medical Information OB Medical Information only GYN Medical Information only

Lab Results Ultrasound Results Pathology Results

Billing /Collections Information Appointments Other _____

I do I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency
Syndrome) or HIV (Human Immunodeficiency Virus), drugs or alcohol.

Information Release To: _____
Name

Address

City, State, Zip

From the time period of _____ to _____.

Signature of Patient

Date

Witness Signature

Date

** It is the patient's responsibility to inform us of any changes.