HIPAA

Legal Name: _____

Date of Birth: _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Women's Group of North Florida (WG) / Gainesville OBGYN (GOG) / Lake City OBGYN (LC) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment, and communication among health professionals contributing to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that WG/GOG/LC are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that WG/GOG/LC reserve the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and electronic media.

I request that the following individual(s) have <u>unrestricted</u> access to information regarding my care and understand that I may revoke this decision at any time.

Name:	Relationship to Me:
_____	_____
_____	_____
_____	_____

My signature below reflects that I fully understand and accept the terms of this consent.

_____ _____

Patient's Signature Date