WOMEN'S HEALTHCARE PARTNERS

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Women's Healthcare Partners to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Women's Healthcare Partners reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, Women's Healthcare Partners 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, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Women's Healthcare Partners may mail to my home or other alternative location any items that assist the practice in carrying out TPO, as long as they are marked "Personal or Confidential."

With this consent, Women's Healthcare Partners may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to request that Women's Healthcare Partners restrict how it uses or discloses my PHI to carry out TPO. 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 allow Women's Healthcare Partners to use and disclose 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, Women's Healthcare Partners may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient's Name Date

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Print Name of Legal Guardian, if applicable