



Women's Healthcare Physicians

A M E D I C A L C O R P O R A T I O N

Patient Consent for Use and Disclosure of Protected Health Information

_____ With your consent, Women's Healthcare Physicians, may use and disclose protected health information
Initial (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 1140 West La Veta, Suite 560, Orange, CA 92868.

_____ With your consent, Women's Healthcare Physicians, may call your home or office and leave a message in
Initial reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

_____ With your consent, Women's Healthcare Physicians, may mail to your home or office any items that assist
Initial the practice in carrying out TPO such as appointment reminder cards and patient statements.

_____ I give my consent to electronically send or fax my records for the purpose of treatment, payment, or
Initial healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve Women's Healthcare Physicians of all liability.

_____ You have the right to request that we restrict how we use or disclose your PHI to carry out treatment,
Initial payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

_____ By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment,
Initial payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian _____ Date _____
This Authorization Will Remain Standing Until Revoked in Writing.

Patient's Name _____ Date of Birth _____

Print Name of Patient or Legal Guardian _____ Date _____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my PHI to carry out treatment, payment, and health care operations.