Andrew G. Woolrich, M.D.
PATIENT ACKNOWLEDGEMENT AND CONSENT FORM
Patient Consent for Use and Disclosure
Of Protected Health Information

I hereby give my consent for the office of **Dr. Andrew G. Woolrich** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by the office of **Dr. Andrew G. Woolrich** describes such uses and disclosures more completely.)

I have seen and been able to review the Notice of Privacy Practices prior to signing this acknowledgement and consent form.

The office of **Dr. Andrew G. Woolrich** reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to **Dr. Andrew G. Woolrich**, 140 East 80th Street, New York, NY 10075.

With this consent, the office of **Dr. Andrew G. Woolrich** may call my home phone or other alternative location and leave a message on voicemail 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. I also authorize the sending of mail to my home or other alternative location of any items that assist the practice in carrying out TPO, such as patient statements and appointment reminder cards as long as they are marked personal and confidential.

I have the right to request that the office of **Dr. Andrew G. Woolrich** 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 the office of **Dr. Andrew G. Woolrich** to use and disclose my PHI to carry out TPO. I acknowledge that I have been the opportunity to review the Notice of Privacy Practices of **Dr. Andrew G. Woolrich**.

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, **Dr. Andrew G. Woolrich** may decline to provide me with treatment.

Signed by: _____ Relationship to patient: _____

Print patient or guardian's name: _____ Date: _____

I (DO) or (DO NOT) give permission for **Dr. Andrew G. Woolrich** and staff to discuss PHI with the person(s) who accompany me to the office.

Patient/Guardian must be provided with a signed copy of this form.