Bluefield Women's Center, P.C.

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Specializing in Obstetrics, Gynecology, Infertility & Advanced Gynecologic Surgery

USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Signature OB/GYN will not condition treatment by your failure to sign this disclosure.

By signing this disclosure I acknowledge that Signature OB/GYN may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Signature OB/GYN may disclose my medical information to a *Business Associate* for the same reasons, and that the *Business Associate* will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Acknowledged and agreed to by:

Patient: _____ **or Representative:** _____

Signature: _____ **Date:** _____

The Federal Government now restricts this office and Signature OB/GYN from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Signature OB/GYN permission to discuss my protected medical information with the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature of Patient: _____ Date _____

Please list daytime telephone number(s) at which you prefer to be reached.

_____ _____

Can we leave a message regarding your protected health information at the number(s) you have provided? ( ) Yes ( ) No