PATIENT’S CONSENT FOR COEUR OBGYN, PLLC TO SHARE PROTECTED HEALTH INFORMATION WITH OTHER NAMED PARTIES

In addition to our normal operational disclosures or privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, billing and options. It is still the responsibility of the below named parties to request this information.

\_\_\_\_\_\_\_\_\_\_\_ I hereby give my consent for Coeur OBGYN, PLLC or their staff to leave information regarding my treatment, results, appointment information, or recommendations on my answering machine at the phone numbers I have provided.

\_\_\_\_\_\_\_\_\_\_\_ I hereby give my permission for Coeur OBGYN, PLLC or his staff to phone me at my work.

\_\_\_\_\_\_\_\_\_\_\_ I hereby give my permission for lab results to be sent to me at the address I have supplied.

\_\_\_\_\_\_\_\_\_\_\_ I hereby give my permission for Coeur OBGYN, PLLC or his staff to discuss my billing account information with the person/persons listed below:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that I may change the above authorizations with a written request at any time. The new authorization will only become effective once a written request is received by Coeur OBGYN, PLLC’s office and is posted by our Privacy Officer.

Please initial the above referenced information you wish to authorize.

My signature acknowledges that I have read and agree to this consent form.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed & Revised:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed & Revised:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed & Revised:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_