**Patient Consent for Use and Disclosure of PHI and NPP Receipt**

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Women’s Healthcare Physicians of Naples, LLC in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient’s protected health information and/or medical record - billing information to the following individual(s) who are the Patient’s family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient.

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 Name Relationship

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 Name Relationship

The Patient agrees that this Organization may disclose the following types of information if contained in the Patient’s medical - billing records (please initial the appropriate categories):

\_\_\_\_\_\_ HIV / AIDS Information

\_\_\_\_\_\_ Mental Health Information

\_\_\_\_\_\_ Substance Abuse Information

\_\_\_\_\_\_ Sexually Transmitted Disease Information

\_\_\_\_\_\_ Pregnancy Information (if Patient under Age 18)

This Organization will utilize the patients address and telephone numbers for communications unless an alternate form of communications (please initial and complete appropriate items below):

\_\_\_\_\_\_ Regular mail with any envelopes marked personal and confidential

\_\_\_\_\_\_ Via other telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I DO**  give Women’s Healthcare Physicians my permission to access my medication list from pharmacy databases. This will insure that my health care providers have my most updated medication list on file at all times.

**YES NO**

May we leave a message on your answering machine at home concerning Pap, pathology, lab testing or any other protected health information?

 **YES NO**

May we leave a message at home confirming or cancelling an appointment?

**YES NO**

May we leave a message at your place of employment to have you return our call?

**YES** **NO**

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

This Organization has published a HIPAA ‘Notice of Privacy Practices’ (NPP). I have been informed and provided a copy of the NPP. Please check one item below:

\_\_\_\_\_\_ NPP Provided

\_\_\_\_\_\_ NPP Previously Provided

\_\_\_\_\_\_ NPP Declined

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENTVERIFYING CONSENT TO THE ABOVE STATED TERMS.**

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**Print Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**AM / PM**

**Patient or Legally Authorized Representative Date Time**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**AM / PM**

**Relationship to Patient If Signed By Another Party Date Time**

Please explain Patient’s Representative Relationship to the patient and include a description of the Representatives authority to act on behalf of the patient.

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