

Please use blue or black ink to complete form.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Peachtree City Obstetrics and Gynecology, P.C. to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). Peachtree City Obstetrics and Gynecology, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

- With this consent, Peachtree City Obstetrics and Gynecology, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as; (1) Appointment reminders with the physician name, appointment date and time, and our telephone number, (2) Insurance items, (3) Any calls pertaining to my clinical care, including laboratory results among others. (A message will be left to call the office. Lab results are not left on your voice mail or with an individual without your consent.)
AGREE _____ **DISAGREE** _____

- With this consent, Peachtree City Obstetrics and Gynecology, P.C. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
AGREE _____ **DISAGREE** _____

- I have the right to request that Peachtree City Obstetrics and Gynecology, P.C. restrict how it uses or discloses my PHI and TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
AGREE _____ **DISAGREE** _____

- We have your permission to speak to the following individual(s) regarding your PHI.

- As a part of an OB/GYN practice, many of our patients will send us photographs of their newborn and/or children we have delivered. We assume that when we receive these photographs you are giving us permission to display them on our display board in the office. If you do not wish these photographs to be displayed, you are responsible for notifying us, in writing, that you do not wish to have the photograph(s) displayed.

AGREE _____ **DISAGREE** _____

By signing this form, I am consenting to Peachtree City Obstetrics and Gynecology, P.C.'s use and disclosure of my PHI to carry TPO.

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, Peachtree City Obstetrics and Gynecology, P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date