Peachtree City Obstetrics and Gynecology, PC

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 a 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 the 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 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, including lab results.

  NAME: _____ **PHONE:** _____

  NAME: _____ **PHONE:** _____

  NAME: _____ **PHONE:** _____

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