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Consent for Use and Disclosure of Health Information

1. This is to inform you that OB/GYN Associates, PA may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your healthcare; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").

2. The use and disclosure of your Protected Health information will be to carry out treatment, payment and healthcare operations of OB/GYN Associates, PA.

3. For a more complete description of how OB/GYN Associates, PA may use and disclose your Protected Health Information, please refer to the attached Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefore, to obtain a revised Notice of Privacy Practices, please contact: Candace Brown, Administrator.

4. You have the right to request that OB/GYN Associates, PA be restricted from using or disclosing your Protected Health Information in carrying out Treatment, Payment or Health Care Operations; however, OB/GYN Associates, PA is not required to agree to your requested restrictions. If OB/GYN Associates, PA does agree to your requested restrictions, then it will comply with your request.

5. You have the right to revoke this Consent. This revocation must be made in writing to OB/GYN Associates, PA. This revocation will be valid except to the extent that OB/GYN Associates, PA has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize OB/GYN Associates, PA to use or disclose your Protected Health Information in conjunction with OB/GYN Associates, PA Treatment, Payment or Healthcare Operations in accordance with the terms of this Consent.

_____ _____
Signature Signature (Authorized Representative)

_____ _____ _____
Date Date of Birth Account Number

I would like to receive a copy of the Use and Disclosure of Health Information: _____ (initials)

Further, I hereby authorize and give my consent to OB/GYN Associates, PA to leave messages on my answering machine/voicemail system and/or cell phone (voice or text) for the following:

☐ Appointment Reminders ☐ Prescription Refills
☐ Medical Information (including returned telephone calls) ☐ Test Results

Further, I hereby authorize and give my consent to OB/GYN Associates, PA to communicate any of my Protected Health Information to the following persons:

Name	Relationship