

ADVANCED HEALTHCARE FOR WOMEN
Experience. Expertise. Excellence.

**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH
INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE
OPERATIONS**

I understand that as part of my health care, Advanced Healthcare for Women originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the healthcare professionals who contribute to my care
- A source of information of applying my diagnoses and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as quality assessments and physician certifications

I understand and have been provided with a copy of your Privacy Practices which gives a more complete description of uses and disclosures of my health information. I have been given the opportunity to review the notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests. I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action relying on this consent. I further understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and accept/decline the terms of this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____