Gynecology Today

Patient Consent for Use and Disclosure of Protected Health Information

I acknowledge that I have received the HIPAA notice and give consent for **Gynecology Today** to use and disclose my protected health information (PHI) for the purpose of medical treatment and/or obtaining payment for services rendered. **(**The Notice of Privacy Practices provided describes such uses and disclosures more completely.)

With this consent, **Gynecology Today,** may call the following phone numbers and leave a message on my voicemail in reference to any items that assist the practice, such as appointment reminders, insurance items, and any calls pertaining to my test results.

Primary: _____ Alternate: _____

OR

_____ I DO NOT WISH TO HAVE A MESSAGE LEFT ON MY VOICEMAIL.

Gynecology Today will not discuss your health information and condition with other family members or person unless you specifically give your written consent.

By signing below, I give consent for **Gynecology Today** to discuss my protected health information with the following individuals:

Name_____ Relationship _____

Name_____ Relationship_____

OR

_____I DO NOT WISH TO HAVE MY INFORMATION SHARED WITH FAMILY MEMBERS.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient's Name Print Name of Legal Guardian if applicable