

OB-GYN Center
305 Virginia Drive
Batesville, AR 72501
870-698-0300

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

With my consent, OB-GYN Center may use and disclose protected health information (PHI) about my to carry out treatment, payment, and healthcare operations (TPO). Please refer to the OB-GYN Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. OB-GYN Center reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to OB-GYN Center, Privacy Officer, 305 Virginia Drive, Batesville, AR 72501.

With my consent, OB-GYN Center may call my home or other designated location and leave a message on voice mail, answering machine, or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results, among others. With my consent, OB-GYN Center may mail to my home or other designated location any items that assist the practice ni carrying out TPO, such as appointment reminder cards, test result cards, and patient statements, as long as they are marked personal and confidential.

I have the right to request that OB-GYN Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to OB-GYN Center'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 form, OB-GYN Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient

Printed Name of Legal Guardian

With my consent, OB-GYN Center may fax, mail, or delivery my PHI to referring physicians, consulting physicians, or family physicians to carry out TPO.

YES

NO

Signature of Patient or Legal Guardian

I have received OB-GYN Center's Notice of Privacy Practices.

Signature of Patient or Legal Guardian