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

NAME: _____

BIRTHDATE _____ **SS #** _____

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information 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 assessing care quality and reviewing the competence of healthcare professionals.

I UNDERSTAND THAT I HAVE THE RIGHT:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION: _____

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I have received a copy of Houston Women's Care Associates Notice of Privacy Practices.

I give my permission to Houston Women's Care Associates to contact me at ANY phone number that I provided on my Patient Information form with regards to collection on my account.

X _____ _____ _____

Signature of Patient or Legal Representative Date Witness Signature