THE OB/GYN CENTRE

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

With my consent, the physicians and staff of The OB/GYN Centre may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the 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. The physicians and staff of The OB/GYN Centre reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by Offer at 6400 Fannin, Suite 1900, Houston, Texas 77030.

With my consent, the physicians and staff of The OB/GYN Centre may call my home or any other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the physicians and staff of The OB/GYN Centre may mail to my home or any other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and test results as long as they are marked "Personal" and/or "Confidential".

With my consent, the physicians and staff of The OB/GYN Centre may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, and test results. I have the right to request that the physicians and staff of The OB/GYN Centre restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this aggreement.

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, the physicians and staff of The OB/GYN Centre may decline to provide treatment to me.

Signature of Patient or Legal Guardian:_____

Printed Name of Patient:_____

Date:_____

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

I give the physicians and staff of The OB/GYN Centre permission to contact me regarding the indicated items in the following manner:

List numbers we can call, circle yes or no if we may leave a detailed message, and indicate type of info we can leave in the message.

Home #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Work #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Cell #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results ☐ Billing ☐ Rx

Email #_____ Message Ok? Yes No

☐ Appointments ☐ Scheduling ☐ Results* ☐ Billing ☐ Rx

*abnormal results will not be sent via email without specific request

Ok to leave messages/discuss with _____
(individual's name/relationship)

☐ Appointments ☐ Scheduling ☐ Results* ☐ Billing ☐ Rx

I give my permissions as above, and I understand that these will remain in force until such time I request a change in writing.

Signature:_____

Date:_____