Consent for Use or Disclosure of Protected Health Information (PHI) for Payment, Treatment and Health Care Operations

By signing below, you hereby consent for Brookwood Women's Health, P.C. (the "Practice") to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI, available at the front desk, before signing this Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Practice's Privacy Officer for a copy.

You also have the right to request that the Practice restrict how your PHI is used or disclosed in carrying out treatment, payment or health care operations. Please be aware, however, that the Practice is not required to agree to these requested restrictions. Should the Practice agree to your requested restrictions, though, the restrictions are binding.

Information about you is protected under federal law, and you have the right to revoke this consent at any time. This revocation will not apply to action(s) the Practice has already taken in reliance on your consent (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed may be subject to redisclosure by the recipient and may no longer be protected under federal law.

Brookwood Women's Health, P.C. may communicate confidential information, including payment invoices and appointment reminders, to me at the following address and/or phone numbers. I understand that I need not supply either, provided I do not wish to be contacted by the Practice. In such case, I agree to pay for all charges incurred during my visit at the time of service.

PLEASE CHECK ONE OR BOTH:

[ ] The Practice may send correspondence to me at the address listed in my patient information file.

[ ] The Practice may leave messages at the following number(s):

Home________________________ Cell__________________________ Work_________________________

I authorize the following persons to communicate on my behalf with the Practice concerning my medical care:

Name:____ Relationship: ______________________

Name:____ Relationship: ______________________

Name:____ Relationship: ______________________

By signing below, I acknowledge the above and give authorization to receive Text and/or Email messages from Brookwood Women's Health, PC. I was also given/offered a copy of Brookwood Women's Health's Notice of Privacy Practices effective 9/23/2013.

My cell phone carrier (for purpose of receiving text messages) is: ____

____ _________________________

Signature of Patient or Legal Guardian **Date**