ROSA
GYNECOLOGY

## PATIENT CONSENT FOR USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION

I Hereby give my consent for Rosa Gynecology to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**). Rosa Gynecology's Notice of Privacy provides a more complete description of such uses and disclosures.

- With this consent, Rosa Gynecology may call my home or other alternative location and leave a message on voice mail or a person in reference to any items that assist the practice in carrying out TPO, such as; (1) Appointment reminders with the physician name, appointment date and time and our telephone number, (2) Insurance items, (3) Any calls pertaining to my clinical care, including laboratory results among others. (A message will be left to call the office. Lab results are not left on your voice mail or with the individual without your consent.)

  **AGREE _____** **DISAGREE _____**

- With this consent, Rosa Gynecology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and statements.

  **AGREE _____** **DISAGREE _____**

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

  **AGREE _____** **DISAGREE _____**

- We have your permission to speak to the following individual(s) regrading your PHI, including lab results.

  **NAME: _____** **PHONE: _____**

  **NAME: _____** **PHONE: _____**

  **NAME: _____** **PHONE: _____**

**By signing this form, I am consenting to Rosa Gynecology's use and disclosure of my PHI to carry out TPO.**

**I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Rosa Gynecology may decline to provide treatment to me.**

_____ _____
Signature or Patient or Legal Guardian Patient's Name

_____ _____
Print Name of Patient or Legal Guardian Date