



Consent for the Use or Disclosure of Protected Health Information

I understand that as part of my healthcare, The Women's Clinic of Northern Colorado originates and maintains health records describing my health history, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I understand that this information serves as:

- A basis for planning my care and treatment, including other healthcare professionals and facilities that contribute care such as pathology and radiology.
- A means for communication among the many healthcare professionals and facilities 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.

Please indicate with the following choices that you consent to:

H-Home B-Business C-Cellular A-All O-Other

- _____ Messages/phone calls regarding appointments
_____ Messages/phone calls regarding lab/test results
_____ Messages/phone calls regarding financial account information

Please **initial** below giving consent to the following:

- _____ Receive information by mail regarding appointments
_____ Receive information by mail regarding lab/test results
_____ Receive information by mail regarding marketing or promotion material.

- _____ If married, provide medical or financial information to spouse
_____ If a minor, provide medical or financial information to legal guardians

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing a restriction request form. I further understand that The Women's Clinic of Northern Colorado is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing a revocation form and returning it to Medical Records at The Women's Clinic of Northern Colorado. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

By signing this consent, I acknowledge that I have read and understand The Women's Clinic of Northern Colorado Notice of Privacy Practices statement.

Signature

Date

Patient Sticker