Circle of Life
Women's Center

Patient Consent to the Use and Disclosure of Personal Health Information (PHI)

I understand that as part of my health care, Circle of Life Women's Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among the many health professionals who contribute to my care.
- A source of information for which we can assess and continually work to improve the care we render and outcomes we achieve.
- 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 quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of medical information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request certain restrictions as to how my PHI may be used or disclosed to carry out treatment, payment, and/or health care operations.

I understand that Circle of Life Women's Center is not required to agree to the restrictions requested. I further understand that I may revoke this consent in writing, except to the extent of action already taken by the clinic. If I wish to make changes to this consent, I agree to do so in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

I wish the following individuals and/or entities (please list their relationship to you) to be <u>RESTRICTED</u> to the use or disclosure of my PHI:

_____
_____
_____
_____

I wish the following individuals and/or entities (please list their relationship to you) to have full/limited <u>ACCESS</u> to my PHI: (please note the extent of information that should be available to this individual and/or entity. For example: test results, medications, diagnoses, treatment, etc. If full access is authorized, it will include any and all reproductive care/treatment. *If no access details are listed below, you are authorizing full access.)

_____
_____
_____
_____

I fully understand and accept the terms of this consent.

Patient Name: _____

Signature: _____ Date: _____