HIPAA CONSENT FORM

CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use/disclosure of my private health information (PHI) by Associates in Women's Health for the purposes of diagnosing, providing care and treatment to me, obtaining payment for my health care bills or conducting health care operations of Associates in Women's Health. I understand that diagnosis or treatment of me by Associates in Women's Health may be conditional upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of this practice. Associates in Women's Health, is not required to agree to the restrictions that I may request. However, if Associates in Women's Health agrees to a restriction that I request, the restriction is binding on Associates in Women's Health.

I have the right to revoke this consent, in writing, at any time, except to the extent that Associates in Women's Health has taken action in reliance on this consent.

My PHI means health information, including demographics, collected from me and created or received by my physician, another health provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or other is a reasonable basis to believe the information may identify me.

I understand I have a right to review Associates in Women's Health's Notice of Privacy Practices prior to signing this document. The Associates in Women's Health's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Associates in Women's Health. The Notice of Privacy Practices for Associates in Women's Health is also provided upon request and in the waiting room. This Notice of Privacy practice's also describes my rights and Associates in Women's Health's duties with respect to my PHI.

Associates in Women's Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practice by calling the office and requesting a revised copy be sent to me in the mail or by asking for one at the time of my next appointment.

Associates in Women's Health endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time

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Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date