All Women's
Obstetrics & Gynecology

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610 Airport Road Suite 210
Huntsville, Alabama 35802

Consent for Use and Disclosure of Health Information

1. This is to inform you that All Women's Obstetrics & Gynecology may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your health care; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").
2. The use and disclosure of your Protected Health Information will be to carry out treatment, payment and healthcare operations of All Women's Obstetrics & Gynecology.
3. For a more complete description of how All Women's Obstetrics & Gynecology may use and disclose your Protected Health Information, please refer to the attached Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefore, to obtain a revised Notice of Privacy Practices, please contact the Privacy Officer.
4. You have the right to request that All Women's Obstetrics & Gynecology be restricted from using and disclosing your Protected Health Information in carrying out Treatment, Payment or Health Care Operations; however, All Women's Obstetrics & Gynecology is not required to agree to your requested restrictions. If All Women's Obstetrics & Gynecology does agree to your requested restrictions, then it will comply with your request.
5. You have the right to revoke this Consent. This revocation must be made in writing to All Women's Obstetrics & Gynecology. This revocation will be valid except to the extent that All Women's Obstetrics & Gynecology has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize All Women's Obstetrics & Gynecology to use or disclose your Protected Health Information in conjunction with All Women's Obstetrics & Gynecology's Treatment, Payment or Healthcare Operations in accordance with the terms of this Consent.

_____ _____
Signature (Patient) Signature (Authorized Representative)

_____ _____ _____
Date Date of Birth Account Number

I have received a copy of the Notice of Privacy Practices :_____(Initials)

Further, I hereby authorize and give my consent to All Women's Obstetrics & Gynecology to leave messages on my answering machine/ voicemail system for the following:

_____ Appointment Reminders _____ Prescription Refills

_____Medical Information (including returned telephone calls _____ Test Results

Further, I hereby authorize and give my consent to All Women's Obstetrics & Gynecology to communicate any of my Protected Health Information to the following persons:

Name	Relationship