COPPERSTATE
OB/GYN
ASSOCIATES LTD.

Women's Health Specialists

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

NAME _____

BIRTH DATE_____SOCIAL SECURITY # _____ _____ _____

I understand that as part of my healthcare, this Copperstate OB/GYN originates and maintains health 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 communication among the many healthcare professionals 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.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I hereby acknowledge that I have been presented with a copy of CopperstateOB/Gyn's Health Specialists Notice of Privacy Practices.

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☐ I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with

- ☐ Patient Only
- ☐ Family member or friend _____
- ☐ Physician
- ☐ Other_____

Detailed messages regarding test results can be left on your answering machine

- ☐ Yes
- ☐ No
- ☐ Phone Number _____

☐ OTHER RESTRICTIONS _____

PATIENT:

X _____ _____ _____

Signature of Patient or Legal Representative | Date | Witness Signature