CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERTIONS

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the patient is a minor under state law.

I hereby authorize Kennesaw Gynecology (the "Practice") to release the following personal health information for:

- Medical services claim information
- Prescription, diagnostic, treatment, and/or care management services
- Reviews required by HHS or HIPAA-compliant healthcare operations

_____ (*Initial*) I hereby consent to Kennesaw Gynecology (the "Practice") disclosing my Protected Health Information (PHI) in the following ways: (i) **For treatment purposes** - the Practice can use my health information and share it with other professionals who are treating me; (ii) **For operational purposes** - the Practice can use and share my PHI to run its practice, improve my care, and contact me when necessary; and (iii) **For payment purposes** - the Practice may share my PHI to bill and receive payment from health plans or other entities.

This consent is effective _____ (today's date)

I want this consent to continue indefinitely until revoked in writing by me.

COMMUNICATIONS WITH YOU

Note: Secure and private communication cannot be guaranteed fully with the use of non-secure technology such as cell/smart phones, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact the Practice or your provider using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner. In the event that you choose not to allow non-secure modes of communication, we will only be able to contact you on a "home" (land-line phone, wire-to-wire fax, or US Postal Service mail). **Please also note:** We do not accept social media friend requests from former or current patients to protect your privacy and maintain a professional boundary in the therapeutic relationship.

How may we communicate with you?

□ Cell Phone #_____ Okay to leave voicemail? □ Yes □ No Consent to text messages? □ Yes □ No
□ Home Phone #_____
□ Mail (address): _____
□ Email (address): _____
□ Video Conferencing/Skype

If there is any person that we MAY talk to regarding our test results if you are not available, please list them below. If you wish us only to speak to you, please write no one.

Person's Name	Relationship to you	Their Daytime phone number

I understand that I have the right to revoke this authorization and consent in writing at any time. I request that my confidential information be handled in the herein authorized manner. Any other release of information will require a signed authorization for Release of Medical Information or Release of Psychotherapy Notes. I assume all risk and responsibility for updating the Practice with any changes in the above-provided information. I understand why I have been asked to disclose this information and I am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Printed Name of Patient: _____ Date _____

_____ _____
Signature of Patient /Legal Guardian (Relationship to Patient)