

Robert Ashmore, M.D.
A.J. Brickler III, M.D.
Arthur Clements, M.D., Ph.D.
David Dixon, D.O.
Alex S. Franz, M.D.
Andrea K. Friall, M.D.



Kenneth McAlpine, M.D.
Vikki McKinnie, M.D.
David O'Bryan, M.D.
Lori W. Rosenberg, M.D.
Terrie Tullos, A.R.N.P.-C.

1401 Centerville Road, Suite 202 • Tallahassee, FL 32308-4638 • (850) 877-7241

Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operations

I the patient (or authorized representative), consent North Florida Women's Care to the use or disclosure of my individually identifiable "protected health information" for the purpose of treatment, payment or healthcare operations as the terms are defined under federal HIPAA privacy rules.

My "protected healthcare information" means health information collected from me or my representative and created or received by my health care provider, another healthcare provider, insurance carrier, my employer or a healthcare clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have the right to revoke this Consent. Such revocation must be submitted to North Florida Women's Care in writing. The revocation shall be effective except to the extent that North Florida Women's Care has already taken action in reliance on the Consent.

North Florida Women's Care may refuse to treat me if I (or an authorized representative) do not sign this Consent form (except to the extent that North Florida Women's Care is required by law to treat individuals). If I (or authorized representative) sign this consent form and then revoke consent, North Florida Women's Care has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that North Florida Women's Care is required by law to treat individuals).

I have received or have been allowed to view a copy (posted in waiting area and at www.nflwc.com) of North Florida Women's Care's "Notice of Privacy Practices" as required by HIPAA.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare options) with: (If no one, leave blank)

Name (Please Print)	Name (Please Print)
Spouse / Partner _____	Child _____
Mother _____	Sibling _____
Father _____	Other _____

Can we leave a message on your answering machine or voice mail concerning lab or test results? I (the patient) understand that answering machines and cell phones are not secure lines.

I understand that North Florida Women's Care may send letters, postcards or leave voice mail messages for appointment reminders and mail billing statements to the Guarantor on my account.

I certify that I am the patient (or authorized representative) and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

_____ Signature of Patient	_____ Date
_____ Please Print	_____ Date of Birth
_____ Authorized Representative Signature	_____ Date
_____ Please Print Name	