north florida Women's Care
OBSTETRICS & GYNECOLOGY

1401 Centerville Road, Suite 202 • Tallahassee, Florida 32308-4638
(850) 877-7241 (Main) • (850) 877-1338 (Fax) • www.NFLWC.com

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

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

My "protected healthcare information" (PHI) 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 health care clearinghouse. The PHI 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, please check here ☐)

Name	**Name**
☐ Spouse/Partner_____	☐ Child _____
☐ Mother_____	☐ Sibling _____
☐ Father_____	☐ Other _____

How may we communicate protected healthcare information (visit summaries, lab results, etc.) with you? I (the patient or authorized representative) understand that answering machines and cell phones are not secure lines. Please check all that apply.

☐ **Patient Portal Secure Message**

☐ **Home Answering Machine**

☐ **Cell Phone Voicemail**

☐ **Postal Mail**

☐ Please check here to opt out of Protected Healthcare Information (PHI) communication via patient portal services. This will mean that you will not receive secure messages regarding results and nurse communication from our offices.

I understand that North Florida Women's Care may send letters, postcards, emails, text messages or leave voice messages for appointment reminders, appointment cancellations, waiting lists, recalls or missed appointments as well as mail or send a secure email message on billing statements to the Guarantor on my account.

I understand it is my responsibility to provide accurate and current demographic information including mailing address, phone numbers and a private personal email address for correspondence with North Florida Women's Care through our secure patient portal and patient newsletter.

I certify that I am the patient (or authorized representative) and that the information given by me to the 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 and Printed Name | Relationship to Patient | Date

Please check which signature appears above (check only one)

☐ Patient

☐ Authorized Representative if Patient is a Minor

_____ _____ _____

Minor's Signature | Printed Name | Date