Womens Health Care Group
of PA
The McConnell Division

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____, understand that as part of my health care, McConnell-Peden-Belden -Finnegan-Icasiano-Devine Associates originates and maintains paper and/or electronics records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves us:

- A basis for planning my care and treatment,
- A means of communication among the many health 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that McConnell-Peden-Belden-Finnegan-Icasiano-Devine Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permtted by section 164.506 of the code of federal regulations.

I further understand that McConnell-Peden-Belden-Finnegan-Icasiano-Devine Associates reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should they change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree,email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize McConnell-Peden-Belden-Finnegan-Icasiano-Devine Associates to furnish my primary care physicians, referring physician, or other treating medical professional any and all information that may be requested regarding my physical or mental condition and treatment rendered there for and, if necessary, to allow them or any physician appointed by them to examine any imaging studies taken of me or records regarding my physical and mental condition or treatment. In addition I also authorize the release of psychiatric/psycho-therapy records, mental health records and drug and/or alcohol treatment records under the same terms and conditions. This authorization shall remain in force until revoked in writing by the undersigned.

Signature:_____ Date: _____

CONFIDENTIALITY

In addition to release of information as authorized in the **AUTHORIZATION TO RELEASE MEDICAL RECORDS**, and in the interest of confidentiality, and compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgment as to whom we may release information to on your behalf is required. This would pertain specifically to personal relations, i.e. family, friends, etc.

I authorize the release of information (health and demographics) as it pertains to my care only to the following. (You may contact our office at any time should you wish to make changes to this authorization.

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Name:_____ Relationship: _____ Phone: _____

Signature:_____

ACKNOWLEDGMENT OF RECEIPT OR PRIVACY NOTICE (*PRIVACY NOTICE ATTACHED)*

I have been presented with McConnell-Peden-Belden-Finnegan-Icasiano-Devine Associates Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I fully understand the contents of the Notice, and I request the following restrictions (if any) concerning the use of my personal information.

_____

_____

_____

Signature:_____ Date: _____

If not signed by patient, please indicate relationship to patient:

Relationship:_____ Witnessed by: _____

_____

Internal Use Only

If patient or patient's representation refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: _____ Time: _____

Name: _____ Signature: _____

This agreement will be in effect for one (1) year from the above date signed.