advanced obgyn

Patient Consent for the Disclosure of Information

In order to continue to provide you with the quality of care you have become accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purposes of **treatment, payment, and operations** (such as quality assurance). In using the information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy & Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Specifically, we will need to disclose your private information under the following circumstances:

- **Sharing information for the purpose of treatment**: We will share information with all members of your treatment team, both within this office and with our providers (personal and institutional) in order to provide you quality care and the educational/wellness programs specified in your insurance plan.
- **Sharing information for the purpose of payment**: We will share all necessary information with your insurer(s), payor(s), government entities (such as Medicare, Medicaid, etc.), and their representatives (including but not limited to)benefit determination and utilization review as well as representatives involved in the billing process (including but not limited to) claims representatives and billing companies.
- **Sharing information for the purpose of operations**: We will share information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer reviews, accreditations, and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your signature indicates your consent has been given freely. You understand that you may revoke this consent at any time if that revocation is in writing, but disclosures given in reliance on this prior consent will be permissible.

Patient's Name (Print) _____

Patient's Signature _____

Parent or Legal Guardian _____

Date Signed _____