Alabama Women's Health Care
-----OB GYN-----

Consent for Use and Disclosure of Health Information

1. This is to inform you that Alabama Women's Health Care may use and disclose your health information that identifies you, and that consists of your past, present or future physical or mental health or condition, the provision of your health care; and the past, present or future payment for the provision of your healthcare (this health information is referred to herein as "Protected Health Information").

2. The use and disclosure of your Protected Health Information will be to carry out treatment, payment and healthcare operations of Alabama Women's Health Care.

3. For a more complete description of how Alabama Women's Health Care may use and disclose your Protected Health Information, please refer to the attached Notice of Privacy Practices. The terms of the Notice of Privacy Practices may change from time to time; therefor to obtain a revised Notice of Privacy Practices please contact our office.

4. You have the right to request that Alabama Women's Health Care be restricted from using or disclosing your Protected Health Information in carrying out Treatment, Payment, or Healthcare Operations; however, Alabama Women's Health Care is not required to agree to your requested restrictions. If Alabama Women's Health Care does agree to your requested restrictions, then it will comply with your request.

5. You have the right to revoke this Consent. The revocation must be made in writing to Alabama Women's Health Care. The revocation will be valid except to the extent that Alabama Women's Health Care, has taken action in reliance on this Consent.

By signing this document, you acknowledge that you have read and understand this Consent. Further, you hereby consent and authorize Alabama Women's Health Care to use or disclose your Protected Health Information in conjunction with Alabama Women's Health Care's Treatment, Payment, or Healthcare Operations in accordance with the terms of this Consent.

_____ _____

Signature (Patient) Signature (Authorized Representative)

_____ _____ _____

Date Date of Birth Account Number

I have Received a copy of the Notice of Privacy Practices:_____(initials)

Further, I hereby authorize and give my consent to Alabama Women's Health Care to leave messages on my answering machine/voicemail system for the following:

_____ Appointment Reminders _____ Prescription refills

_____ Medical Information (including returned telephone calls) _____ Test Results

Further, I hereby authorize and give my consent to Alabama Women's Healthcare, to communicate any of my Protected Health Information to the following persons:

Name	Relationship