AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT,

PAYMENT OR HEALTH CARE OPERATIONS

I ____ (Patient's full name) , ________________ (DOB), hereby authorize the release or use of my individual identifiable health information (PHI- "Protected Health Information") and medical record information by Total Woman Healthcare, PA in order to carry out treatment , payment, or health care operations. You should review the Total Woman Healthcare, PA notice of privacy practices for a more complete description of the potential release and use of such information. You have the right to review such notice prior to signing this consent form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my PHI & medical records information, confirm or change appointment times and speak to the office on my behalf, with the following individuals who are my family members, legal representatives, guardians, healthcare surrogates, or have power of attorney:

Name	Date	Relationship

Any additional individuals should be listed on the back of this form if needed.
I agree and have been given notice that the Practice may also disclose the following types of information contained in my medical record to the appropriate authorities as we are required by Florida State Law 384.25. (Please initial all categories below):

__________ HIV/AIDS Information ___________ Mental Health Information __________ Substance Abuse Information

__________ Sexually Transmitted Disease Information ________ if patient is under the age of eighteen (18), pregnancy information

I understand that if the practice needs to contact mem it will be via the primary phone number listed in my file. I agree to keep this number updated at all times and understand that my demographics are my responsibility. I acknowledge that I can update my demographics through several sources, I can update them in the office directly, through a call to the phone center, or through my patient portal. Should the practice need to communicate with me, and my phone is unavailable, after 3 attempts a certified letter will be sent through the mail. I elect for correspondence to be directed to me in the optional form of:

Email or Fax (please circle one) fax number or email to be used: ____

At all times, you retain the right to revoke this consent, such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The practice may refuse to treat you. If you (or an authorized representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent, I have received a copy of this consent and I am the patient or the authorized party to act

on behalf of the patient to sign this document verifying consent to the above terms.

Date: ________________________ Time: ______________________ AM/PM

Signature of Patient or Authorize Representative:

X____

If you are not the patient, please describe your relationship to the patient and include a description of the Representative's authority to act on the behalf of the patient:

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