

**PATIENT INFORMATION CONSENT FORM**

I have read and fully understand Laurel Ob-Gyn, PA's Privacy Notification. I understand that Laurel Ob-Gyn, PA may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed. If I choose to restrict how my PHI is used or disclosed I understand it must be submitted to Laurel Ob-Gyn, PA in writing. Restrictions are considered on a case-by-case basis.

I have been given a copy of the short form of the "Notice of Patient Information Practices" and understand that I may obtain a copy of the complete version, which is posted in the lobby upon request.

I hereby consent to the use and disclosure of my personal health information for the purposes as outlined in Laurel Ob-Gyn, PA's Privacy Notice. ***I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.***

I hereby authorize Laurel Ob-Gyn to release any PHI regarding my treatment, payment, or lab results. I understand that Laurel Ob-Gyn will verify the identity of the party listed below before any such information is given.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**With the implementation of our new computer system we now have the ability to confirm your appointments electronically. Please provide the very best phone number for us to call. This number will also be used as the primary contact number for you regarding your health care, lab results, and financial information.**

**\*\*IT IS VERY IMPORTANT THAT IF YOU ONLY WANT APPOINTMENT CONFIRMATION CALLS TO THIS NUMBER AND NO HEALTH INFORMATION MESSAGES LEFT THAT YOU CLEARLY CHECK THE BOX PROVIDED\*\*.**

**I ONLY WANT APPOINTMENT CONFIRMATION CALLS TO (\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_ PHONE NUMBER. I REQUEST NO HEALTH INFORMATION LEFT ON THIS NUMBER.**

**I HEREBY GIVE LAUREL OB-GYN PERMISSION TO LEAVE A MESSAGE REGARDING MY HEALTHCARE, LAB RESULTS, FINANCIAL INFORMATION, AND APPOINTMENT CONFIRMATIONS ON THE BELOW VOICEMAIL.**

(\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_

**OR** (\_\_\_\_)\_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date