



Northside
WOMEN'S HEALTH

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Northside Women's Health
Privacy Consent - For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy in respect to your health care information.

I hereby give my consent to Northside Women's Health, LLC and any employee working under the directions of the physician, to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include services related to my health (or the identified person) and may include (but not limited to) preventative diagnostic, therapeutic rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent included contract and discussion with other health care professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice.

Consent related to the Privacy Notice: I have had the chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed by this practice is not required to agree to my restrictions. If it does agree to my restrictions n PHI, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time by the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives the notice.

Patient or Guardian _____ Date _____

Name Printed _____ Relationship to Patient _____

Consent for assignment to benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co payments, amounts applied to deductible and other amount that me be deemed my responsibility by payment sources, as required by my insurance plan and state regulation. I further understand that my contract with this insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about services not covered. If I seek care outside of this contract, I am aware I may be responsible for all charges that are incurred.

Patient/Guardian _____ Date _____