Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintains health records, describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I authorize the release of any medical information to my insurance carrier which is necessary to process my insurance claims. I also authorize my insurance benefits to be paid directly to my physician, realizing that I am responsible to pay for non-covered services.

I have received a Notice of Privacy Practices that provides a more complete description of how my medical information may be used and disclosed and how I can get access to this information. The Notice of Privacy Practices can also be viewed on our website: www.gynfredericksburg.com

I understand that the organization reserves the right to amend, change or eliminate provisions in our Notice of Privacy Practices and to enact new provisions regarding the protected health information we maintain. If our Notice of Privacy Practices is amended, you are entitled to receive a revised copy of the "Notice" by calling and requesting a copy of our "Notice" or by visiting our office or downloading a copy from our website.

If I want to exercise any of the Health Information Rights listed in the Notice of Privacy Practices, I will contact Gynecology Associates of Fredericksburg, 221 Park Hill Drive, Fredericksburg, VA 22401 at 540-386-1986, Attn: Privacy Official.

I understand that I may revoke this consent in writing, except to the extent that Gynecology Associates of Fredericksburg has already taken action. **Authorizations will expire two years from the date this form is signed.**

By registering my email address, I agree to receiving appointment reminders and other general office information at this email address. No protected health information will be sent to this email address.
I choose to register the following email address: _____
I wish to allow the disclosure of my health information to the following:
_____
I authorize the release of my lab results or other tests such as x-rays, CT scans, MRI, Sonograms to:
_____
I authorize _____ to pick up prescriptions on my behalf.
I authorize _____ to speak to the billing employees of GYN Associates of Fredericksburg.
I fully understand and accept the terms of this agreement. (Please sign)

Name _____ Date:_____