

Highland Ob / GYN Clinic, P.A.

David A. Schutzer, MD ♦♦♦ Kelley Saunders, CNM

2301 Robeson Street, Suite 201  
Fayetteville, NC 28305

Phone: (910) 485-1191 / Fax: (910) 485-6006

### **Patient Consent Form**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 3 Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- 4 Obtain payment from third party-payers
- 5 Conduct normal health care operations such as quality assessments and physician certifications.

I consent to the use or disclosure of my protected health information by the Highland OB/GYN Clinic, PA for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Highland OB/GYN Clinic, PA

I understand that diagnosis or treatment of me by the health care providers of the Highland OB/GYN Clinic, PA may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The Highland OB/GYN Clinic, PA is not required to agree to the restrictions that I may request. However, if the Highland OB/GYN Clinic, PA agrees to the restriction that I request, the restriction is binding on the Highland OB/GYN Clinic, PA, its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent the Highland OB/GYN Clinic, PA has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This “protected health information” relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that the information may identify me.

I have been offered a copy of the Highland OB/GYN Clinic, PA Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of health care operations of the Highland OB/GYN Clinic, PA

A copy of the Notice of Privacy Practices for the Highland OB/GYN Clinic, PA is located at the reception desk and in the reception area. This Notice of Privacy also describes my rights and the Highland OB/GYN Clinic, PA duties with respect to my protected health information.

The Highland OB/GYN Clinic, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking at the time of my next appointment.

I do \_\_\_ I do not \_\_\_ consent to have my physician’s office call me for reminders for appointments.

I do \_\_\_ I do not \_\_\_ consent to have my physician's office mail me for reminders for appointments.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_