

## River Rose Obstetrics & Gynecology

### PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for River Rose Ob/Gyn (Athens Medical Associates) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. River Rose Ob/Gyn's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. River Rose Ob/Gyn reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice Of Privacy Practices may be obtained by forwarding a written request to River Rose Ob/Gyn, Privacy Officer at 75 Hospital Drive, Suite 260, Athens, OH 45701.

With this consent, representatives of River Rose Ob/Gyn may call my home or other alternative locations and leave a message on my voice mail, or in person, in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including lab results among others.

With this consent, representatives of River Rose Ob/Gyn may mail to my home or other alternative locations any items that assist the practice in carrying out healthcare delivery, such as appointment reminder cards and patient statements.

I have the right to request that representatives of River Rose Ob/Gyn restrict how they use or disclose my personal information to carry out healthcare operations. I will submit such requests in writing addressed to the Privacy Officer.

By signing this form, I am consenting to River Rose Ob/Gyn's use and disclosure of my personal healthcare information to carry out healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, River Rose Ob/Gyn may decline to provide treatment to me.

If you would like a copy of this consent, please let one of our staff know.

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Printed Patient Name

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Date

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Signature of Patient  
or Legal Guardian if patient is under 18 years of age

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Printed Name of Guardian