fleur
WOMEN'S HEALTH

PATIENT CONSENT FORM TO USE & DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

By signing this form, you are granting consent to Fleur Woman's Health Center to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our NOTICE OF PRIVACY PRACTICES provides more detailed information about how we may Use and Disclose this protected health information. You have a legal right to review our NOTICE OF PRIVACY PRACTICES before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we Use and Disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have Used or Disclosed your protected health information in reliance on your consent.

FLEUR Woman's Health Center may disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to their involvement in your care or the payment of your care. Fleur women's Health also may notify a family member or another person responsible for your care, of your location and general health condition. Please initial one of the following to indicate your choice regarding such disclosures:

_____**I CONSENT** to disclose my personal health information to a family member, friend, or another individual involved in my care. Please name the person(s) allowed:

_____

_____

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_____

_____**I OBJECT** to disclose my personal health information to a family member, friend, or another individual involved in my care.

Reason for Rejection: _____

_____ OR _____

Patient Name (please print) Patient Legal Representative (print)

_____ _____

Date Relationship to Patient