

Associates in OB GYN, S.C.

**Consent for Release and Use of Confidential Information and
Receipt of Notice of Privacy Practices Form**

I _____, hereby give my consent to Associates in Ob Gyn
Patient Name or Authorized Person

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information
contained in the patient record of _____.
Patient's Name

I acknowledge the receipt of the Associates in Ob-Gyn Notice of Privacy Practices. The Notice of Privacy Practices
provides detailed information about how the practice may use and disclose my confidential information.

I understand that Associates in Ob-Gyn has reserved the right to change the privacy practices that are described in this
Notice. I also understand that a copy of any Revised Notice will be provided to me upon request or made available on
Associates in Ob-Gyn's website at: www.associatesinobgyn.net.

I understand that this consent is valid until it is revoked by me. I also understand that I may revoke this consent at any
time by giving written notice of my desire to do so to Associates in Ob-Gyn. I also understand that I will not be able to
revoke this consent in cases where Associates in Ob-Gyn has already relied on it to use or disclose my health information.
Written revocation of consent must be sent to Associates in Ob-Gyn.

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient