Patient Consent for Physicians to Use or Disclose Healthcare Information for Treatment, Payment and Healthcare Operations

Patients Name: _____
Date of Birth: _____ SS # : _____ / _____ / _____

I, _____, understand that my health information is private and confidential. I understand that the JRWC works very hard to protect my privacy and preserve the confidentiality of my personal health information. I also understand that signing this document means that the JRWC may use and disclose my personal health information to help provide healthcare to me, to handle billing & payment, and to take care of other health operations. Failure to sign this consent may result in the physician declining to treat me.

Jackson Regional Women's Center has a detailed document called "Notice of Privacy Practice" . it contains more information about policies and practices used to protect their patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. The JRWC may update this "Notice of Privacy Practices" if I ask, they will provide me with the most current copy.
Under the terms of consent, I can ask the JRWC to restrict how my personal health information is used or disclosed to carry out treatment, payment, or healthcare operations, I understand that the JRWC does not have to agree to my request. If Jackson Regional Women's Center does not agree to my request, I understand that the JRWC would follow the agreed limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel this consent, I understand that the JRWC may have already used or disclosed information about me and canceling the consent would not affect the information previously used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that the JRWC can give me called "Revocation of Consent for Use and Disclosure of Healthcare Information" , or
2. Writing, signing, and dating a letter to the JRWC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, or healthcare operations.

I understand that if I refuse to sign or cancel this consent, Jackson Regional Women's Center does not have to provide any further healthcare service to me.

My signature below indicates that I have been given the chance to review a current copy of Jackson Regional Women's Center's "Notice of Privacy Practice"

_____ _____
Signature of Patient or Personal Representative Printed Name of Patient/Representative

_____ _____
Date Relationship to Patient
(if personal representative)

*if personal Representative, the patient is unable to sign because (check one)
☐ Minor ☐ Incompetent ☐ Other: _____
**I understand the JRWC has made available to me for my information the Privacy Practices for Jackson Regional Women's Center regarding the use of my Protected Health Information.
I have chosen to: ☐ Receive a Copy ☐ Not to Receive a Copy