FAYETTEVILLE WOMAN'S CARE, INC
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Fayetteville Woman's Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Please refer to Fayetteville Woman's Care Notice of Privacy Practices for a more compete description of such uses and disclosures.

Fayetteville Woman's Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Fayetteville Woman's Care Privacy Officer at 2029 Valley Gate Dr, ste. 101, Fayetteville, NC 28304.

With my consent, Fayetteville Woman's Care may call my home (_____) or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, such as laboratory results. In the space provided, I can specify alternative phone numbers where Fayetteville Woman's Care can attempt to contact me.

With my consent, Fayetteville Woman's Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements, as long as they are marked confidential. I agree to allow Fayetteville Woman's Care to send appointment reminder cards that may disclose the nature of their business.

With my consent, Fayetteville Woman's Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, Such as appointment reminder cards and patient statements. I have the right to request that Fayetteville Woman's Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Fayetteville Woman's Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. This form will be valid for one year from the date of my signature. If I do not sign this consent, Fayetteville Woman's Care may decline to provide treatment to me.

(Fayetteville Woman's Care will verify identity of patient by complete or partial social security number and date of birth when calling a patient.) Alternate Numbers:

_____	_____	_____	_____
Home	Work	Cell	Other(please specify)

Below please list the family members or other persons, if any, whom we may inform about your **general medical condition and your diagnosis.**

List Names:_____

Below please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

_____	_____
Name	Phone Number
_____	_____
Name	Phone Number

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number. _____"I am fully aware that a cell phone is not a secure and private line."

_____	_____
Patient/Guardian Signature	Date
_____	_____
Clinic Employee Witness	Date

Patient Name_____ DOB____/____/____ Chart #_____