Authorization for Release of Protected Health Information

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Patient's Name or Authorized Agent (Please Print): _____

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I hereby give my consent to Advanced Gynecology Associates of Augusta to use and disclose, for the purpose of carrying out Treatment, Payment, or Health Care Operations (TPO), all information contained in my patient record.

With this consent, Advanced Gynecology Specialists of Augusta may call my home or other alternative location and leave a message on voicemail or in person in reference to items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Advanced Gynecology Specialists of Augusta may mail to my home or other alternative location my items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Advanced Gynecology Specialists of Augusta's use and disclosure of my Protected Health Information (PHI) to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Gynecology Specialists of Augusta may decline to provide treatment to me.

_____ _____
Signature of Patient Date

Authorization of Release of Protected Health Information to Family Members
I authorize Advanced Gynecology Specialists of Augusta to release protected health information to my family member(s) listed below:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Signature of Patient Date