

**Gynecological & Obstetric Associates, S.C.**

**Patient Consent for Use and Disclosure  
of Protected Information**

With my consent, Gynecological & Obstetric Associates may use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

Please refer to Gynecological & Obstetric Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gynecological & Obstetric Associates 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: Gynecological & Obstetric Associates, attention: Privacy Officer, 675 W. Central Road, Suite 100C, Arlington Heights, IL 60005.

With my consent, Gynecological & Obstetric Associates may contact me at the addresses (including E-mail) and phone numbers indicated on my Patient Information form in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, medical invoices and anything pertaining to my clinical care, including **laboratory results** among others.

I authorize Gynecological & Obstetric Associates to leave a detailed medical information message on voice mail or in person at the phone numbers indicated on my Patient Information form.

I authorize messages and information to be discussed with the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that Gynecological & Obstetric Associates will mark any mail sent to the home address indicated on my Patient Information form as, "Personal and Confidential".

I understand that if I do not want Gynecological & Obstetric Associates to contact me at a specific address, phone number or E-mail then I should not include it on my Patient Information form.

Unless otherwise noted, I will be referred to by my first name while in the physician's office.

I have the right to request that Gynecological & Obstetric Associates restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Gynecological & Obstetric Associates use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Gynecological & Obstetric Associates will expect payment in full at the time that services are rendered.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient