Professional Women's Healthcare, P.A.
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CONSENT TO USE OF DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

The Patient hereby consents to the use or disclosure of her individually identifiable health information ("protected health information or PHI") by Professional Women's Healthcare, P.A. ("PWHC") in order to carry out treatment, payment, or healthcare operations. The Patient should review PWHC's Notice of Privacy Policies for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

PWHC reserves the right to change the terms of its Notice of Privacy Policies at any time. If PWHC does change the terms of its Notice of Privacy Policies, the Patient may obtain a copy of the revised Notice upon request.

Patient retains the right to request that PWHC further restrict how her PHI is used or disclosed to carry out treatment, payment or healthcare operations. PWHC is not required to agree to such restrictions (unless required by law); however, if PWHC does agree to Patient's required restrictions; such restrictions are then binding of PWHC.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to PWHC in writing. The revocation shall be effective except to the extent that PWHC has already taken action in reliance on the Consent.

PWHC may refuse to treat Patient if she (of an authorized representative) does not sign this Consent (except to the extent required by law). If Patient (or an authorized representative) signs this Consent and then revokes it, PWHC has the right to refuse to provide further treatment to Patient as of the time of the revocation (except to the extent required by law).

If you consent to the following, Please initial below:

_____ I understand and acknowledge receipt of Professional Women's Healthcare, P.A's Notice of Privacy Practices. If I wish to receive a hard copy, one will be provided to me upon my request.

_____ I agree that Professional Women's Healthcare, P.A. may electronically obtain my prescription history from a third-party pharmacy database, in order to update my health records.

_____ I agree that Professional Women's Healthcare, P.A. may electronically send me information related to my health record via its Patient Portal (please make sure we have your current email on file).

____________________	____________________	__________	__________
Patient's Signature	Printed Name	DOB	Date

____________________	____________________	__________
Authorized Representative's Signature	Printed Name	Date

____________________	____________________	__________
Witness's Signature	Printed Name	Date

*Please state Authorized Representative's relationship to Patient and provide us with any documents pertaining to your authority to act on behalf of the Patient: ____