

Atlanta GYN Center, P.C.

Rita Sharma, MD
1922 Northlake Parkway
Tucker, GA 30084

Tel(770)723-1545

Fax(770)723-1546

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Atlanta GYN Center, P.C. to use and disclose Protected Health Information ("PHI") about me to carry out Treatment, Payment and Healthcare Operations ("TPO"). (Please refer to Atlanta GYN Center, P.C.'s Privacy Practice for a more complete description of such uses and disclosures of Protected Health Information or PHI).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta GYN Center, P.C. 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 Privacy Office of Atlanta GYN Center, P.C. at 1922 Northlake Parkway, Tucker, GA 30084.

With this consent, Atlanta GYN Center, P.C. may call my home or other alternative location to speak with me or leave a message on voicemail, home answering machine, or with a family member in reference to any 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, Atlanta GYN Center, P.C. may mail to my home or other alternative location any 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.

With this consent, Atlanta GYN Center, P.C. may e-mail to my home or other alternative 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 Atlanta GYN Center, P.C. restrict how it uses or discloses my PHI to carry out TPO, provided that my restrictions would not hinder Atlanta GYN Center, P.C. from carrying out the TPO services. Atlanta GYN Center, P.C. is not required to agree with my requested restrictions, especially if these restrictions are not reasonable. However, Atlanta GYN Center, P.C. is bound by this agreement if it does not agree with my requested restrictions. **WE DO E-MAIL APPOINTMENT REMINDERS.** Please make sure we have your E-Mail address

By signing this form, I am consenting to Atlanta GYN Center, P.C. 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. If I do not sign this consent, or later revoke it, Atlanta GYN Center, P.C. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Patient's Name (Please Print)

Patient's Date of Birth

Patient's Social Security Number

Print Name of Legal Guardian

Relationship to the Patient