Complete WOMENS CARE CENTER

obstetrics gynecology menopause fertility wellness cosmetic gynecology

Patient Name: _____

Date of Birth: _____

Today's Date: _____

All of us at Complete Women's Care Center care deeply about the privacy of your personal health information. We are required by Federal Law to share the following information with you and obtain your consent to share your information with your insurance company and other necessary parties.

Notice of Privacy Practices. By signing below, I acknowledge that I have received the practice's Notice of Privacy Practices. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices

Release of Information. By signing below, I hereby permit Complete Women's Care Center and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, or healthcare operations.

Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases.

If the Patient is 18 years or older:

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

*If patient is less than 18 years old, results will be discussed with parent/legal guardian and patient. In Texas, information regarding pregnancy and/or STDs can be communicated directly to minors.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We respectfully request permission to contact you via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

_____I consent to receive text messages and emails for the purposed stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information

_____ I DO NOT consent to receive text messages and emails for the purposed stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is

_____.

Consent for Photography for Recognition and Chart Identification

We respectfully request to photograph you for purposes of ease of recognition and electronic chart identification

____ I consent to a photograph for the purposes listed above. Images in which I am identified will not be released to any other parties without my specific consent.

____ I DO NOT consent to photography for the purposes listed above.

Patient or Parent/Legal Guardian (if patient is a minor) Signature _____Date:_____

Patient or Parent/Legal Guardian (if patient is a minor) (Printed): _____ DOB: _____