

Tifton Woman's Center Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients went into effect. H.I.P.P.A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Tifton Woman's Center requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent.

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Individual Name	Relationship	Phone Number
Individual Name	Relationship	Phone Number
***You have the right to revolution of the result of the r	te this consent, in writing, except where prior consent.	e we have already made
Patient's Signature		Date
Patient's Printed Name		