Island Women's Care

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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Island Women's Care, LLC in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manner(s):

VIA MAIL — PLEASE INITIAL

☐ OK to Mail to home address _____

VIA HOME TELEPHONE

☐ OK to leave a detailed message _____
☐ Leave call back number only _____

VIA CELL PHONE

☐ OK to leave detailed message _____
☐ Leave call back number only _____

The following persons may speak to Island Women's Care, LLC regarding my health information:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE

Printed Name of Patient: _____ Date: ____/____/____

Signature of Insured/Guardian: _____ Date: ____/____/____