

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Section A: Patient or Authorized Legal Guardian Giving Consent

Name: _____
(required)

Address: _____
(required)

Telephone: _____ E-Mail: _____
(required)

Patient Name: _____ ID# _____
(required) (required)

Section B: Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available, which will contain the changes.

Right to Revoke: You have the right to revoke this consent at any time by submitting written notice of your revocation to the contact person listed below. Revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Acknowledgement of Receipt and Signature

I have read the contents of the consent form and I hereby certify that I have received and read your Notice of Privacy Practices. I understand that by signing this consent form, I am giving permission for use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I hereby certify that I am the legal guardian of the above referenced patient or have otherwise been empowered to give consent on behalf of this patient for the use and disclosure of protected health information.

Printed Name of Recipient

_____/_____/_____
Date

Signature of Recipient

Privacy Officer: **Vanessa White – Practice Manager**
St. Louis Gynecology & Oncology, LLC
11652 Studt Ave
St. Louis, MO 63141

For Office Use Only

We attempted to obtain written consent and acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

- Communication barriers prohibited obtaining the acknowledgement/consent
- Emergency situation prevented us from obtaining acknowledgement/consent
- Other(Please specify)

