Augusta & Waterville Women's Care

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Augusta & Waterville Women's Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to August & Waterville Women's Care Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Augusta & Waterville Women's Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a handwritten request to Augusta & Waterville Women's Care at 35 Medical Center Parkway., Suite 202, Augusta, ME 04330.

With my consent, Augusta & Waterville Women's Care may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Augusta & Waterville Women's Care may mail to my home or other designated location any items that assist in the practice carrying out TPO, such as appointment cards, laboratory/pathology results and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Augusta & Waterville Women's Care restrict how it uses and discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Augusta & Waterville Women's Care 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, Augusta & Waterville Women's Care may decline to provide treatment to me.

X _____

Patient's Name: _____

Date: _____