

**MT. PLEASANT OB/GYN
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Mt. Pleasant Ob/Gyn may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mt. Pleasant Ob/Gyn's Notice of Privacy Practices for a more complete description of such uses and disclosures and patient rights. Copies of this notice may be found in the waiting room. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Mt. Pleasant Ob/Gyn reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Amy Warner, Privacy Officer at 1400 Hospital Drive, Mt. Pleasant, SC 29464.

With my consent, Mt. Pleasant Ob/Gyn may call my home or other designated location and leave a message on voice mail 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, Mt. Pleasant Ob/Gyn may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Mt. Pleasant Ob/Gyn restrict how it uses or 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 Mt. Pleasant Ob/Gyn's use and disclosure of my Protected Health Information to carry out Treatment, Payment and Healthcare Operations.

I may revoke this 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, Mt. Pleasant Ob/Gyn may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian