



Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by the Counseling & Gynecology Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conducting health care operations of the Counseling & Gynecology Group. I understand that diagnosis or treatment of me by Dr. Max Chorowski, Jenifer Fleming, Amanda Bush or Tiana Mirapae may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The Counseling & Gynecology Group is not required to agree to the restrictions that I may request. However, if the Counseling & Gynecology Group agrees to a restriction that I request, the restriction is binding on the Counseling & Gynecology Group and Dr. Max Chorowski, Jenifer Fleming, Amanda Bush and Tiana Mirapae.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Max Chorowski, Jenifer Fleming, Amanda Bush or Tiana Mirapae, or the Counseling & Gynecology Group has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Counseling & Gynecology Group's Notice of Privacy Practices prior to signing this document. The Counseling & Gynecology Group's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Counseling & Gynecology Group, including contacting me by telephone or by postcard to remind me of an appointment or the need to make an appointment.

The Notice of Privacy Practices for the Counseling & Gynecology Group also is posted in the office of the practice's Privacy Officer. This Notice of Privacy Practices describes my rights and the Counseling & Gynecology Group's duties with respect to my protected health information.

The Counseling & Gynecology Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting that a revised copy be sent in the mail or by asking for one at the time of my next appointment. This consent must be retained in my file for a period of six years.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date