RHETT WOMEN'S CENTER

Patient Acknowledgement of the Notice of Privacy Practices and Consent for Use and Disclosure of Personal Health Information

We use and disclose health/telehealth information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health/telehealth information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Please list anyone that we may share your medical history with_____

_____

☐Please do not share my medical history with anyone unless otherwise indicated in writing.

Payment: We may use and disclose your health/telehealth information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health/telehealth information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health/telehealth information for treatment, payment or healthcare operations, you may give us written authorization to use your health/telehealth information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health/telehealth information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health/telehealth information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose health/telehealth information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health/telehealth information to provide you with appointment reminders (Such as voicemail messages or text messages).

Access: You have the right to look at or get copies of your health/telehealth information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

I acknowledge that I have been presented with a copy of the Notice of Privacy Practices, which details how my information may be used and disclosed as permitted under federal and state law. I understand the contents of this notice.

_____ _____

Patient Date of Birth

_____ _____

Signature of Patient/Parent/Legal Guardian Date

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