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Consent to Use or Disclose Information for Treatment, Payment or Healthcare Operation

I the patient (or authorized representative consent Lily ob/gyn to the use or disclosure of my individually identifiable "protected health information: for the purpose of treatment, payment or healthcare operations as the terms are defined under federal HIPAA privacy rules.

My "protected healthcare information" means health information collected from me or my representative and created or received by my health care provider, another healthcare provider, insurance carrier, my employer or a healthcare clearinghouse. The 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 have the right to revoke this Consent. Such revocation must be submitted to Lily ob/gyn in writing. The revocation shall be effective except to the extent that Lily ob/gyn has already taken action in reliance on the Consent.

I have received or have been allowed to view a copy of Lily ob/gyn's "Notice of Privacy Practices" as required by HIPAA.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and healthcare option with (if no one, leave blank):

Name (print)	Phone #	Relationship

May we leave a message on your answering machine or voicemail concerning lab or test results? I (the patient) understand that answering machines and voicemails are not secure lines.

Yes ________ No ________

I understand that Lily ob/gyn may send letters, postcards or leave voice messages for appointment reminders and mail billing statement to the Guarantor on my account. I certify that I am the patient (or authorized representative) and that the information given by me to the Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

______________________________ ______________________

Name of Patient Date

____

Signature of Patient

______________________________ ______________________

Security question Answer