ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

Notice of Privacy Practices. Partners in Women's Healthcare has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Revisions to Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. Copies of revised notices will be available at the reception desk or by submitting a written request to our privacy officer.

How to contact our privacy officer

Mail: Partners in Women's Healthcare, PC
Attention: Privacy Officer
Address: 1 Lemoyne Square Plaza, Suite 201
Lemoyne, PA 17043

Telephone: (717) 737-4511 extension 125
Fax: (717) 737-5940

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Partners in Women's Healthcare. Partners in Women's Healthcare is authorized to use and disclose health information about

____ / ______________________________

(Patient Name) (Date of Birth)

for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices including discussions with family members (unless otherwise requested).

X____ ________________________

Signature of patient or personal representative Date

____

Name and relationship of personal representative (if applicable)

Insurance Authorization / Financial Responsibility

I authorize payment of medical benefits to Partners in Women's Healthcare, PC for services rendered by any of the physicians or non-physician professional staff. I authorize release of any information to my insurance carrier to determine benefits payable for services rendered. I agree to accept financial responsibility for payment of services determined to be non-covered by my insurance. If I am uninsured at time of service, I agree to accept complete financial responsibility.

X____ ______________________

Signature of Patient/ Personal Representative Date