EMERALD OBSTETRICS AND GYNECOLOGY, LLC
CONSENT FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ (DOB: _____) understand that as part of my healthcare EMERALD OBSTETRICS AND GYNECOLOGY, LLC (EMERALD OBSTETRICS AND GYNECOLOGY) creates and maintains records of my protected health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care treatment or to conduct health care operations. I hereby consent to the use and/or disclosure of my protected health information for these purposes.

I understand that my protected health information includes any information about my health that has been created or received by EMERALD OBSTETRICS AND GYNECOLOGY, my physician, another health care provider, my health insurance plan, my employer, or a health care clearinghouse and may include health information related to my past, present, and future physical or mental health or condition and that this health information identifies me or may be used to identify me.

I understand that I must sign this form or EMERALD OBSTETRICS AND GYNECOLOGY may refuse to provide health care services to me. I also understand that EMERALD OBSTETRICS AND GYNECOLOGY's treatment practices may include sending out postcard reminders and notices regarding my continuing health care and that my name may be included in a directory for internal use by EMERALD OBSTETRICS AND GYNECOLOGY.

I have been provided a copy and understand that I have the right to read and review EMERALD OBSTETRICS AND GYNECOLOGY's Notice of Privacy Practices before signing this consent form. EMERALD OBSTETRICS AND GYNECOLOGY's Notice of Privacy Practices provides a more complete description of the uses and disclosures of my protected health information and my rights related to this use and disclosure of my protected health information. I understand that EMERALD OBSTETRICS AND GYNECOLOGY may change the practices described in its Notice of Privacy Practices. I understand that EMERALD OBSTETRICS AND GYNECOLOGY's Notice of Privacy Practices will be posted in the office and that I may receive a revised copy of the Notice of Privacy Practices, if I ask for one.

I understand and acknowledge that I have the right to request that EMERALD OBSTETRICS AND GYNECOLOGY restrict how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that EMERALD OBSTETRICS AND GYNECOLOGY is not required to agree to the restrictions that I request, but if it does agree to my requested restrictions then EMERALD OBSTETRICS AND GYNECOLOGY is bound by those restrictions. I request the following restriction(s) to the use or disclosure of my protected health information:

_____

_____

EMERALD OBSTETRICS AND GYNECOLOGY, LLC hereby ☐ **Accepts** ☐ **Denies** this requested restriction.

_____ _____
EMERALD OBSTETRICS AND GYNECOLOGY, LLC representative Date

_____
Title

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that EMERALD OBSTETRICS AND GYNECOLOGY, LLC has already take action in reliance upon it.

_____ _____
Signature of Patient or Legal Representative Printed name of Patient or Legal Representative

_____ _____
Relationship to Patient: Date: