Exclusive Medical Provider

Patient Consent for Use and Disclosure of Protected Health Information

_____ _____ _____/_____/_____

Patient Name (please print) Former name if applicable Date of Birth

_____ _____/_____/_____ _____

Patient or legally authorized individual **signature** and **Date** Relationship (parent, legal guardian, personal representative, etc

From: _____ Phone (_____)_____-_____

Address: _____ Fax: (_____)_____-_____

_____ **ALL FIELDS REQUIRED**

With my consent**, Marisol Health and their provider Bella Natural Women's Care,** may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations.

Marisol Health, through their provider Bella Natural Women's Care, will be my primary care office.

Please send a copy of the following records (any of which apply) to Marisol Health and/or Bella Natural Women's Care.

I. My Authorization

You may use or disclose the following health care information (check all that apply)

- ☐ **All my health information maintained by previous health care providers (Circle "include" or "exclude")**
  - ○ **Include or Exclude: My health information related to drug abuse**
  - ○ **Include or Exclude: My health information related to alcohol abuse**
  - ○ **Include or Exclude: My health information related to HIV/AIDS**
  - ○ **Include or Exclude: My health information related to psychological or psychiatric condition**

- ☐ **My health information relating to the following treatments or conditions:**_____
- ☐ **My health information for the dates:** _____
- ☐ **Other:** _____

Reasons for this authorization (check all that apply):

- ☐ **At my request**
- ☐ **Other(specify):**_____

II. My Rights

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- **To receive health care when the purpose is to create health information for third party.**

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above name practice based upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance.

To revoke this authorization, write a letter to the office and it will be put in your chart.
Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.