CAPITAL WOMEN'S CARE
Working Together for Women's Health

301.279.9400

CWCOBGYNDOCS.COM

Use and Disclosure of Protected Health Information

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Capital Women's Care, may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Capital Women's Care Locations.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

_____

Patient's Signature Date

_____

Print Full Name EMAIL ADDRESS

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Capital Women's Care, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any in formation needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

_____

Patient's Signature Date

_____

Print Full Name

Section III (Optional): PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

_____

Name of Authorized Person or Entity Relationship Phone #

_____

Name of Authorized Person or Entity Relationship Phone #

please continue …TURN OVER . . .

Section IV: AUTHORIZATION FOR USE OF EMAIL AND/OR VOICE MAIL

Capital Women's Care physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health care Information that we may possibly disclose on your home, work, or cell phone or email would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) Yes, I **agree** to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information **via email AND on all three communication devices: home, work and cell phone**.

Please initial next to the applicable communication and provide the email address /number of the device:

EMAIL _____ (initial) _____ (EMAIL ADDRESS)
HOME phone _____ (initial) _____ (home phone number)
WORK phone _____ (initial) _____ (work phone number, extension, if applicable)
CELL phone _____ (initial) _____ (cell phone number)

Please indicate your preferred method/s of communication: ____ email ____home ____ work ____ cell

_____ (Initial) Yes, I **agree** to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information **on the following ONLY (be sure to provide address and/or number above)**:

_____ EMAIL _____ HOME PHONE _____ WORK PHONE _____ CELL PHONE

_____ (Initial) No, I **do not agree** to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information via email or on my home, work and cell phone or email.

_____
Patient's Signature Date

For CWC Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ____/____/____, but was unable for the following reason:

_____

_____

_____
CWC Employee Signature Date

_____
Print Name in Full

FOR MORE INFORMATION OR TO REPORT A PROBLEM:
If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.