Susan Fox, D.O.
F.A.C.O.O.G.

Natalya Medrano, M.D.
F.A.C.O.G

Dr. SUSANFOX'S center for women

Office: (305) 595-6488

Susan Fox, DO, FACOOG
Laura Briz, ARNP
Natalya Medrano, MD, FACOG

Fax: (305) 595-3532

New Patient Consent to Use Disclosure of Health Information, Treatment, Payment or Healthcare Operation

I _____, understand that as part of my healthcare Dr. Susan Fox's Center for Women originates and maintains paper and electronics records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- ✓ A basis for planning my care and treatment.
- ✓ A means of communication among the many health professionals who contribute to my care.
- ✓ A source of information for applying my diagnosis and surgical information to my bill.
- ✓ A means by which a third-party payer can verify that services billed were actually provided.
- ✓ A toll for routine healthcare operations such as assessing quality and renewing the competence of healthcare professionals.

I understand and I have been provided with *a Noticed of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- ✓ The right to review the notice prior to signing this consent.
- ✓ The right to object to use of my health information for directory purposes.
- ✓ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Dr. Susan Fox's Center for Women is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of Code Federal Regulations. I further understand that Dr. Susan Fox's Center for Women reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal regulation. Should Dr. Susan Fox's Center for Women change their notice, they will send me a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree email).
I wish to have the following restrictions to the use or disclosure of my health information: _____

_____.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosure via fax. I fully understand and ☐accept or ☐decline the term of this.

I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Signature: _____ Date: _____/_____ /_____

FOR OFFICE USE ONLY
☐Consent Review by: _____ on: _____/_____/_____
☐Consent refused by patient and treatment refused as permitted.
☐Consent added to the patient's medical record on: _____/_____/_____