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

Read before signing the Acknowledgment and Consent

This acknowledgment of notice and consent authorizes Women's Lifecycles to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices: Women's Lifecycles 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.

Amendments: 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. You may obtain a revised notice by submitting a written request to our privacy office/office manager.

How to contact our privacy office/office manager:

Address mail to: Women's Lifecycles
Attention: Privacy Officer/Office Manager
530 Kenhorst Blvd.
Reading, PA 19611
Telephone: 610-775-7133
Facsimile: 610-775-8658

Acknowledgment and Consent

I acknowledge that I received the Notice of Privacy Practices for Women's Lifecycles. Women's Lifecycles is authorized to use and disclose health information about _____
Patient name
for treatment, payment and healthcare purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient (**see below if patient under age 18)** Date

Parent information if patient under age 18 or personal representative information (if applicable):

_____
Signature of parent if patient under age 18 or name of personal representative

_____
Relationship to patient

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION
Read entire document before signing

This authorization gives Women's Lifecycles permission to use and/or disclose health information about you.

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Right to revoke. You may revoke this authorization at any time except to the extent that action has already been taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer/office manager at the above address.

Re-disclosure. If the person or entity that receives your health information in accord with this authorization is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by the federal privacy rule or another privacy law.

Authorized uses and disclosures

Print all information except signature.

1. Patient name:_____

2. I give permission to Women's Lifecycles to disclose all medical information. (Yes (No disclosure
I give permission to Women's Lifecycles to disclose all medical information except:
Please be specific.

_____

3. Provide the name and relationship of person(s) who may receive your medical information:

_____

4. The information will be disclosed for the following purposes: ("At the request of patient" is sufficient for uses and disclosures initiated by the patient.)_____

5. Expiration date of authorization –_____

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient as described in this authorization.

_____ _____
Signature of patient (or personal representative) Date

_____ _____
Signature of parent if patient under age 18 or name of personal rep. Relationship to patient