



Consent to Use and Disclosure of Protected Health Information (PHI)

We are required by law to maintain the privacy of your Protected Health Information (PHI), to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in HIPPA Regulations form 45 CFR 164.

Your PHI will be used by Trinity Ob/Gyn (the practice) or disclosed to others for the purpose of treatment, patient safety, obtaining payment/reimbursement, or supporting the day to day health care operations of the practice. This includes Electronic Medical Records that may be shared by other providers or staff during hospital visits.

Your Rights Concerning Your Protected Health Information: You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the practice.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. The practice is not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e- mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.

Trinity Ob/Gyn, PLLC

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Fax: 704-706-3073**

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Revocation of Consent:

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Trinity Ob/Gyn reserves the right to modify the privacy practices outlined in the notice.

Signature:

I have reviewed this consent form and give my permission to Trinity Ob/Gyn to use and disclose my health information in accordance with it.

_____ (Print Name) _____ (Date)

_____ (Signature)