PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **Southwest Obstetrics and Gynecology, LLC** (the practice) to use and/or disclose protected health information (PHI) about me to carry out treatment, payment, and other healthcare operations (TPO). The Notice of Privacy Practices provides a more complete explanation of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Attn: Privacy Officer, Southwest OB/GYN, 634 West Pinon Street, Suite I, Farmington, New Mexico 87401.

With this consent, the practice may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results.

With this consent, the practice may mail to my home or other alternative location any items that assist in TPO, such as appointment reminder cards and patient statements as long as marked Personal and Confidential.

With this consent, the practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

By signing this form, I am consenting to the practices use and disclosure of my PHI to carry out TPO. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the practice may decline to provide treatment to me.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient Name — Date

_____

Print Name of Parent or Legal Guardian