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The Women's Group of Northwestern
OBSTETRICS AND GYNECOLOGY
www.womenobgyn.net

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AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I, _____, hereby give my consent to The Women's
(*Name of Patient or Authorized Agent)*
Group of Northwestern to use and disclose, for the purpose of carrying out **treatment, payment, or health care operations (TPO)**, all information contained in the patient record of _____.
(Patient's Name)

With this consent, The Women's Group of Northwestern may mail to my home or alternative location, email and/or text my items that assist the practice in carrying out TPO, such as appointment reminder notifications and patient statements, as long as they are marked Personal and Confidential. The Women's Group may also retrieve any personal health information that relates to my prescription history.

By signing this form, I am consenting to The Women's Group of Northwestern use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Women's Group of Northwestern may decline to provide treatment to me.

I would like to be contacted via: ***(please circle one)*** **Text Message** **Email** **Automated Voice Call** regarding any lab results and/or appointment reminders. I am giving authorization to leave a detailed message on the following numbers: YES ☐ NO ☐

Cell Phone #:_____ Home Phone #:_____ Work Phone#:_____

Email Address:_____

Signature: _____ Date: _____

AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

I authorize The Women's Group of Northwestern to release protected health information to my family member(s) listed below:

Name	**Relationship**	**Contact Number**
_____	_____	(____) _____-_____
_____	_____	(____) _____-_____

Signature: _____ Date: _____

PHARMACY UPDATE:

Preferred Pharmacy Name: _____ Phone Number (____) _____-_____

Address: _____ City: _____State:_____ Zip:_____