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

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION 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 Group of Northwestern
(*Name of Patient or Authorized Agent)*
to use and disclose, for 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, lab result notifications and patient statements, as long as they are marked Personal and Confidential. The Women's Group of Northwestern may also retrieve any personal health information that relates to my prescription history. I understand that if information is emailed or sent via text message, there may be some level of risk that this information could be read by an unauthorized party. By providing my mobile telephone number and email address, I am accepting the risks and authorizing the Women's Group of Northwestern, its physicians and staff to communicate with me electronically about my care including normal lab results and appointment reminders, account, service, surveys, new services offered and/or education. I will be provided the option to "Opt Out" on each text and automated email I receive.

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. **My current email to be used is:** _____ .

I am giving authorization to leave a detailed message on the following numbers, if email or text message fails:
YES ☐ NO ☐
Cell Phone#: _____ Home Phone #: _____ Work Phone#: _____

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: _____