Consent for use and disclosure of Health Care information

Patient Name _____ Date _____

My health information is a private matter. Advanced Women's Health and Medi -Spa has a form that tells me how AWH handles my health information. This form is called "Notice of Privacy Practices." If I ask, AWH will provide me with the most current "Notice" before I sign this consent. AWH may update this "Notice" at any time. If I ask, I will get a copy of the most current "Notice." I agree that AWH may use and disclose my information to complete other health care operations. In general, no other uses or disclosures of my health information will occur unless I tell AWH it is okay. Sometimes the law may allow the release of information without my permission. These situations are unusual. One example would be if a patient threatened to harm themselves or someone else. I can ask AWH to further limit the use or disclosure of my health information. AWH is not required to agree to my request. If AWH agrees to any part of my request, AWH would have to follow the agreed limits.

I may cancel this consent at any time, by doing the following:

- **Signing and dating a revocation form. I may obtain this form from AWH**
- **Writing, signing, and dating a letter to AWH. The letter must say that I consent to authorize the use and disclosure of my health information for treatment, payment, and healthcare operations.**

If I cancel this consent:

- **It will be effective except for actions already taken based upon the consent; and AWH will not have to provide any further health care services to me.**

I have been given the chance to read a current copy of AWH's "Notice of Privacy Practices." I agree to allow AWH to use and disclose my health information to carry out treatment, payment, and health care operations.

_____ _____ _____
Patient or legal guardian Date Time

_____
Relationship to patient if signed on behalf of patient
By parent, Legal guardian, personal representative, etc

ADVANCED WOMEN'S HEALTH
2102 NORTH PEARL ST. SUITE 405 TACOMA, WA 98406

Revocation of Consent for Use and Disclosure of Health Care Information

Patient Name_____Date_____Time_____

I no longer want Advanced Women's Health and Medi-Spa (AWH) to use and disclose health care information about me for treatment, billing, payment, and health care operations.

I understand that:

- **This request applies after I sign this document.**
- **AWH is allowed, by law, to use and disclose my health care information to complete treatment, billing, payment, and health care operations already in progress. I agreed to this when I signed the "Consent or Use and Disclosure of Health Care information" document.**
- **AWH is allowed or required by law to release health care information without my permission under certain circumstances, described in the "consent for Use and Disclosure of Health Care Information" document.**
- **AWH does not have to provide any further health care services to me**

_____ _____ _____
Patient or Legal guardian Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, Legal guardian, personal representative, etc.

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