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CORNERSTONE
WOMEN'S CARE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Cornerstone Women's Care P.C., may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Cornerstone Women's Care, P.C. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cornerstone Women's Care, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by sending a written request to Cornerstone Women's Care, P.C., Privacy Officer at 15255 N 40th St. #105, Phoenix, AZ 85032.

With my consent, Cornerstone Women's Care, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I consent, in order for Cornerstone Women's Care, P.C. to service my account or to collect any amounts I may owe, to let them contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. I may be contacted by sending text messages or e-mails, using any e-mail address I provided to Cornerstone Women's Care, P.C. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

With my consent, Cornerstone Women's Care, P.C. may mail to my home or other designated 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 Cornerstone Women's Care, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

By signing this form, I am consenting to Cornerstone Women's Care, P.C. 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 disclosures in reliance upon my prior consent. If I do not sign this consent, Cornerstone Women's Care, P.C. may decline to provide treatment to me.

Advance Directives information has been made available to me.
Patient's Right's & Responsibilities have been made available to me.

I authorize this office to discuss my medical care or treatment with the following person(s):

Name: _____ Relationship: _____ Patient Initials: ____

Name: _____ Relationship: _____ Patient Initials: ____

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian