NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____ understand that as a part of my healthcare, Greenwich Village GYN, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and, surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a NOTICE of PRIVACY PRACTICES that provides more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Greenwich Village GYN, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as a part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

I fully understand and **accept / decline** the terms of this consent.

Patient's Signature _____ **Date** _____