Summit
OBSTETRICS & GYNECOLOGY, PSC
A Comprehensive Center For Women

Summit Obstetrics & Gynecology, PSC
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USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. Summit Obstetrics & Gynecology, PSC will not condition treatment by your failure to sign this disclosure.

By signing this disclosure, I acknowledge that Summit Obstetrics & Gynecology, PSC may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered. I am aware that Summit Obstetrics & Gynecology, PSC may disclose my medical information to a *Business Associate* for the same reasons, and that the *Business Associate* will be bound by all appropriate legal restrictions.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA.

Please list daytime telephone number(s) at which you prefer to be reached.

_____ _____

Acknowledged and agreed to by:

Patient:_____ or Representative:_____

Signature:_____ Date:_____

The Federal Government now restricts Summit Obstetrics & Gynecology, PSC from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant Summit Obstetrics & Gynecology, PSC permission to discuss my protected medical information with the following individuals:

_____ _____
Name Relationship

_____ _____
Name Relationship

Signature of Patient:_____ Date_____