

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Solis Women’s Health Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information.

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Solis Women’s Health must have my consent. Therefore, I authorize Solis Women’s Health to disclose my PHI as described on this form, to the recipients listed below:

Description of the information to be disclosed (check all that apply):

- All Procedures Sonograms Biopsies
- Mammograms Bone Density Other

Name(s) of the person(s) authorized to obtain the above mentioned information. Example: physicians other than your referring doctor, family members, other specified person(s).

Name _____ Relationship _____

Name _____ Relationship _____

OR

I do not authorize Solis Women’s Health to release my PHI to anyone other than myself. I fully understand that by doing so it may take longer to get my results.

Contact Information

I authorize Solis Women’s Health to contact me at the following numbers with results or questions:

Home _____ Cell _____ Work _____

May we leave results on your answering machine or voicemail? (Circle one) Yes No

By providing my email address in the space below, I authorize Solis Women’s Health to send my PHI (Private Health Information) and other electronic communication.

Email Address _____

I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. Further, I understand this consent can be revoked at any time except to the extent that disclosure in good faith has already occurred in reliance to this consent. Otherwise, this shall remain in effect for 360 days.

Patient/Representative Signature: _____ Relationship: _____

Date: _____ Witness Signature: _____

