Section III (Optional):
PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES
AUTHORIZED ACCESS
TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR
DISCLOSED

Name or specifically identify these persons and /or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	Relationship	Phone #
Name of Authorized Person or Entity	Relationship	Phone #

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Capital Women's Care physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health care information that we may possibly disclose on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

____(Initial) Yes, I agree to allow Capital Women's Care physicians and healthcare staff to leave Messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

____(Initial) I agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices:
_____home number, _____work number or _____ cell number.

____(Initial) No, I do not agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

Patient's Signature Date

Patient's Legal Guardian/Authorized Representative Signature Date

Capital Women's Care, LLC
Capital Women's Care Specialty Center, LLC
ENK SurgiCenter, LLC
Minor HIPAA
Use and Disclosure of Protected Health Information

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Capital Women's Care, LLC, Capital Women's Care Specialty Center, LLC and ENK Surgery Center, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Capital Women's Care Locations. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices.***

Patient's Signature Date

Print Patient's Full Name Date

Patient's Legal Guardian/Authorized Representative Signature Date

Print Legal Guardian/Authorized Representative Full Name Date

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Capital Women's Care, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release it to the Centers for Medicare/Medicaid Services and its agent and /or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature Date

Print Patient's Full Name Date

Patient's Legal Guardian/Authorized Representative Signature Date

Patient's Legal Guardian/Authorized Representative Signature Date

OVER →

For CWC Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKOWLEDEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

_____

_____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on

____/_____/_____, but was unable for the following reason:

_____

_____

_____

CWC Employee Signature Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.