The Casella Center for Advanced Gynecology, LLC

Peter J. Casella, MD FACOG

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **The Casella Center for Advanced Gynecology, LLC** may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and health operations (TPO). Please refer to **The Casella Center for Advanced Gynecology, LLC**, Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. **The Casella Center for Advanced Gynecology, LLC** reserves the right to revise its Notice of Privacy Practices.

With my consent, **The Casella Center for Advanced Gynecology, LLC** may call home or other designated location (s) and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **The Casella Center for Advanced Gynecology, LLC** 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 as long as they are marked "Personal and Confidential."

With my consent, **The Casella Center for Advanced Gynecology, LLC** may email my appointment reminder cards and patient statements. I have the right to request that **The Casella Center for Advanced Gynecology, LLC** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **The Casella Center for Advanced Gynecology, LLC** the 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 disclosure in reliance upon my prior consent. If I do not sign this consent, **The Casella Center for Advanced Gynecology, LLC** may decline to provide treatment to me.

_____

Print Patient Name

_____ _____

Signature of Patient / Parent (if minor) Date

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