Trilogy Women's Health, P.A.

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Trilogy Women's Health, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Trilogy Women's Health, P.A. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Trilogy Women's Health, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Trilogy Women's Health, P.A.'s Privacy Officer at 1631 Lancaster Drive, Suite 220, Grapevine, Texas 76051.

With my consent, Trilogy Women's Health, P.A. may call my home or other designated location and leave a message on voicemail 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, Trilogy Women's Health, P.A. 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, Trilogy Women's Health, P.A. may email 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. I have the right to request that Trilogy Women's Health, P.A. 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 Trilogy Women's Health, P.A.'s 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 disclosures in reliance upon my prior consent. If I do not sign this consent, Trilogy Women's Health, P.A. may decline to provide treatment to me.

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Patient's Name

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Print Name of Patient or Legal Guardian

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Signature of Patient or Legal Guardian

_____

Date