WOMEN OB-GYN ASSOCIATES, P.C.
Obstetrics & Gynecology
4121 FAIRVIEW AVENUE, SUITE 201
DOWNERS GROVE, IL 60515

Naheed R. Akhter, M.D., FACOG **Phone (630) 719-9229**
Amy K. Gaunt, M.D., FACOG **Fax (630) 719-9452**

Consent For Release Of Information For Treatment, Payment, and Healthcare Operations

The Health Insurance Portability and Accountability Act (HIPAA) requires that Women OB-Gyn Associates P.C. make available to you a description of how medical information about you may be used or disclosed and how you can get access to this information. This is called the Notice of Privacy Practices and copies are available from the receptionists. I acknowledge that a copy of this notice has been made available to me.

Women OB-Gyn Associates, P.C. is also required to obtain a consent from you to allow us to communicate with you (or anyone you designate), your insurance and companies, and your other healthcare providers. I understand that this consent is voluntary and can be revoked (in writing) at any time. I understand that Women OB-Gyn Associates P.C. can elect not to treat me if I do not provide this consent or choose to revoke it.

I,__________________________, authorize Women OB-Gyn Associates P.C. to use or disclose my health information to carry out my treatment, obtain payment, and for healthcare operations. In addition, I authorize the following:

1.) My medical condition and information may be discussed with the following persons:

Name______________________________Relationship________________

Name______________________________Relationship________________

2.) May we call, email or text you appointment confirmations? YES NO
3.) May we call/leave a message with a person who answers your home phone? YES NO
4.) May we call/leave a message on your cell phone. YES NO
5.) May we contact you/leave voicemail message at work? YES NO

____ ______________
Signature of patient (or patient's representative) Date

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Printed name of patient (or patient's representative)

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Representative's relationship to patient