Progressive Womens Healthcare SC

MONA GHOSH, MD

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, _____,
(Name of Patient or Authorized Agent: Last, First, Middle)

hereby give my consent to Mona Ghosh, MD to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of

_____.
(Patient's Name: Last, First, Middle)

I acknowledge the receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the office of Ishwar K. Patel, MD, SC.

Excellent communication is a very important part of providing quality health care. In an effort to provide you with the timeliest information regarding our health care, we are asking you to complete the following information:

Contact by Phone:

During Day time: __ Home __ Work __ Cellular
During Evening time: __ Home __ Work __ Cellular

Leave messages on Answering Machine/Voice Mail: __ Yes __ No

Leave messages with any other Person: __ Yes __ No

If yes, with whom? _____

Contact by Fax: __ Yes __ No

Contact by Mail at Home Address: __ Yes __ No

Any other request: _____

If there are any changes to the above information, it is my responsibility to contact the office with changes.

Signed: _____ Date: _____

Patient's Social Security Number: _____ Patient's Date of Birth: _____

If you are not the patient, please specify your relationship to the patient: _____