# GENESIS OB/GYN

## CONSENT FORM
## (Please Print)

### Patient Information Consent Form

I have read and fully understand Genesis OB/GYN's Privacy Notification. I understand that Genesis OB/GYN may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Genesis OB/GYN will consider requests for restrictions on a case-by-case basis, but does not have to agree to request for restrictions.

I have a right to receive the notice of privacy practices available in the lobby listed as "Notice of Patient Information Practices" and understand that the staff of Genesis OB/GYN is available to answer any questions I may have about the privacy practices. I hereby consent to the use and discloser of my personal health information for purposes as outlined in Genesis OB/GYN's Privacy Notice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____ _____

Patient's Name | Signature of Patient or Parent/Guardian | Date

### Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

### Authorization for Treatment

I hereby consent to medical treatment, diagnostic procedures and injections by providers and staff of Genesis OB/GYN. I understand diagnostic procedures may include, but are not limited to lab tests on blood, urine, and tissue. I understand I may be asked to undergo diagnostic radiology procedures including, but not limited to, ultrasound. I understand I have the right to ask questions about my treatment and/or procedures and I agree to notify my provider of my concerns.

I have read the above and agree to treatment to their content:

_____ _____

Patient Signature | Date