



# **Heartland Women's Health Care, P.C.**

## **Receipt of Notice of Privacy Practice Form**

### RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

AND

### PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received and read a copy of the Notice of Privacy Practices of Heartland Women's Health Care, P.C. (hereafter referred to as Heartland or the practice).

I hereby give my consent to Heartland to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Heartland Women's Health Care, P.C.'s Notice of Privacy Practices provides 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. Heartland 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 Heartland's Privacy Officer at Heartland Women's Health Care, P.C., 2790 Clay Edwards Drive, Suite 530, North Kansas City, MO 64116.

With this consent, Heartland may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This includes, among others, appointment reminders, insurance items, laboratory results and anything pertaining to my care.

With this consent, Heartland may mail to my home or other alternative location any items that assist the practice in carrying out TPO. Such items may include appointment reminder cards and patient statements.

With this consent, Heartland may e-mail my home or other alternative location any items that may assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Heartland 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 Heartland Women's Health Care, P.C.'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, or later revoke this consent, Heartland Women's Health Care, P.C. may decline to provide treatment to me.

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Patient Signature

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Date

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Parent / Guardian Name (Print)

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Signature