Women Ob-Gyn Associates
Trusted ob-gyn healthcare for the adult woman

Obstetrics & Gynecology
4121 FAIRVIEW AVENUE, SUITE 201
DOWNERS GROVE, IL 60515

Naheed R. Akhter, M.D., FACOG
Elaine R. Cheng, M.D., FACOG **Telephone (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 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 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 can elect not to treat me if I do not provide this consent or choose to revoke it.

I,_____, authorize Women OB-GYN Associates 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) Leave a message on my home phone voicemail or answering machine. YES ___ NO ___
3) Leave a message with a person who answers my home phone. YES ___ NO ___
4) Leave a message on my cell phone. YES ___ NO ___
5) Receive mail at home from our office. YES ___ NO ___
6) Contact me at work and tell them who is calling if asked. YES ___ NO ___
7) Leave a message on my work phone voicemail or answering machine. YES ___ NO ___

_____ _____
Signature of patient (or patient's representative) Date

_____
Printed name of patient (or patient's representative)

_____
Representative's relationship to patient