Orrego Center for Women´s Health
Delivering Women´s Care with Compassion

John Orrego,MD Carolyn DeWalden,PA-C

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Orrego Center for Women's Health, LLC may use and disclose Protected Health Information (PHI) about me or my children to carry out treatment, payment and healthcare operations (TPO). Please refer to Orrego Center for Women's Health, LLC's Notice of Privacy Practices for 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. Orrego Center for Women's health, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised copy may be obtained by forwarding a written request to Orrego Center for Women's Health, LLC's privacy officer at 2714 Rew Circle, Ocoee, FL 34761.

With my consent, Orrego Center for Women's Health, LLC, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
With my consent, Orrego Center for Women's Health, LLC may mail to my home or other designated location any items that assist the practice in caring out (TPO), such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

I have the right to request that Orrego Center for Women's Health, LLC restrict how it uses or discloses my PHI to carry out TPO. However, Orrego Center for Women's Health, LLA is not required to agree my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Orrego Center for Women's Health, LLC the use and disclosure of my PHI to carry out TPO.
The following person (people) may receive information about me:

_____, with DOB: _____. Relationship:_____

and/or _____, with DOB: _____. Relationship: _____

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, Orrego Center for Women's Health, LLC may decline to provide treatment to me.

_____ _____ _____/_____/20___
Name Signature Date

-2714 Rew Circle. Ocoee, FL 34761 Phone: 407-614 0078 Fax: 407-614 0169
-1715 E. Hwy 50, Bldg 3, Ste A Phone: 352-708 6511 Fax: 352-708 6533
Clermont, FL 34711