Diegmann & Henderson OBGYN P.C.

Fred F. Diegmann, M.D.
Bret T. Henderson, M.D.
150 South Ingleside St. Suite 2
Fairhope, AL 36532
(251) 990-6550

CONSENT FOR USE AND DISCLOUSER OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPTIONS:

By signing below I, ____, hereby give my consent for the practice listed above, and it's allowed associates, to contact me by using any telephone numbers (including mobile phones), email addresses, and text messaging I have listed in my medical chart. I allow them to use or disclose information about myself (or another person for whom I have authority to sign for) that is protected under federal law, for purpose of treatment, appointment reminders, payment, collections, and other health care operations.

I certify that I have read the Notice of Privacy Practices for PHI by signing this consent. I understand that the terms of the Notice my change at any time and I am responsible to request an updated version if needed.

____________________________________ ____________________________

Signature of Patient or Legal Guardian Date

____________________________________ _____________________________

Witness Date

PERMISSION TO RELEASE HEALTH INFORMATION:

In the event that our office is unable to reach you (the patient) directly concerning (but not limited to) test results, pathology reports, and other medical information, it is up to your discretion with whom we may share this information with. Please refer to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with any questions.

By signing below you indicate that this consent extends to the person(s) that you (or persons that you have the authority to sign for) have selected and listed below, indefinitely from the date listed on this consent, unless otherwise changed by you in writing:

Myself and those listed below:

1. Full Name: ________________________ 2. Full Name: __________________________

   Phone #: __________________________ Phone #: ____________________________

Myself Only

____ _________________________

Signature of Patient or Legal Guardian Date

____ __________________________

Witness Date

Copyright: © Diegmann & Henderson OBGYN P.C. 2016
All Rights Reserved.