Associates in Women's Health of the Mahoning Valley, Inc.
1350 Fifth Avenue • Suite 324 • Youngstown, OH 44504 • P: 330.746.7007 • 330.746.8818

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & LEGAL RESPONSIBILITIES

With my consent, Associates In Women's Health of the Mahoning Valley, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Please refer to Associates In Women's Health of the Mahoning Valley, Inc.'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. Associates In Women's Health of the Mahoning Valley, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Associates In Women's Health of the Mahoning Valley, Inc. 1350 Fifth Avenue #324 Youngstown, OH 44504 or by an in-office request.

With my consent, Associates In Women's Health of the Mahoning Valley, Inc. may call my home or other designated location and leave a message on the voicemail or in person in reference to any items that assist in caring out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others. With my consent, Associates In Women's Health of the Mahoning Valley, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Associates In Women's Health of the Mahoning Valley, Inc.'s use and disclosure of my PHI to carry out TPO. By signing this form I am also acknowledging receipt of the Notice of Privacy Practices.

I may revoke my consent and/or assignment in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I and/or my representative agree not to bring a frivolous medical malpractice case or cause of action against Dr. Rodney Hill. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Dr. Rodney Hill. I also agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witness(es) in the area(s) of medicine and/or nursing that would typically have the background and experience to opine on such a case. In consideration for this, Dr. Rodney E. Hill agrees to the same stipulations. If I do not sign this consent, Associates In Women's Health of the Mahoning Valley, Inc. may decline to provide treatment for me.

I have read and understand the above information and agree to accept my financial and legal responsibilities.

_____
SIGNATURE of Patient or Legal Guardian

_____ Date_____
PRINT PATIENT'S NAME

_____ _____
PRINT NAME OF LEGAL GUARDIAN RELATIONSHIP TO PATIENT