Lake Obstetrics and Gynecology, Inc.

GENERAL CONSENT

SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

This is the consent form for you to authorize Lake Obstetrics and Gynecology, Inc. (Lake OB/GYN) to provide Services to the Patient named below. Lake OB/GYN performs Services in a variety of settings, including medical centers, doctor's offices, and health centers. Those who provide the Services may not be physicians. Services may be provided by independent practitioners including physicians, who are not employees or agents of Lake OB/GYN. At times Lake OB/GYN is a teaching facility and healthcare personnel in training may be present and participate in providing care. Lake OB/GYN is not responsible for the acts or omissions of healthcare personnel who are not directly controlled by Lake OB/GYN. As used in this form, Services are the diagnostic, therapeutic, medical, physician, nursing, technical, and/or surgical services and/or procedures and associated support, including, but not limited to, photographs, and laboratory testing necessary for care and quality assurance. Services may be provided through telehealth, utilizing technology to connect me and/or data about me to providers who may not be in the physical location. Except in some circumstances, such as an emergency, any Services will be performed after I have been informed of the benefits and material risks associated with such Services and I have given my verbal consent. I understand that the Services do not guarantee a specific outcome or recovery.

By signing below, I, as or on behalf of the Patient, consent to receive and authorize Lake OB/GYN to provide the Services.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

www.lakeobgyn.net

Authorization to Access & Release Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for purposes:

- Required by State and/or Federal law; in cooperation with a law enforcement investigation;
- To conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and/or indirectly;
- Billing, collecting payment for Services, and obtain payment from third-party payers;
- To conduct normal healthcare operations as quality assessments, risk management, physician certifications, and participation in health information exchange(s), including CliniSync, patient registries, or as otherwise authorized and for any other permissible purpose.

Lake Obstetrics & Gynecology retains medical records in accordance with applicable law. I have been informed of the Lake OB/GYN *Notice of Privacy Practices* containing a more complete description of how Lake OB/GYN may access and/or release all or any part of Patient information and I have been given the rights to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing to Lake OB/GYN to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Lake OB/GYN is not required to agree to my requested restrictions, but if agreed then are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relying on this consent.

Patient name ____ Date _________________________

Signature ____

Name of Person signing, if other than patient ____

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this General Consent and Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: