Women's Health For Life, Inc.
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Lima, OH 45801

HIPAA PRIVACY NOTICE CONSENT FORM

By signing this form I acknowledge that I have received and read the patient Notice of Privacy Policy, Financial Policy and HIPAA Notice and my signature acknowledges my understanding.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:
Please choose one of the following:

_____ Patient ONLY **OR**

_____You may disclose my medical information to:

Please release info to: Print name	Relationship	Phone number	DOB
Please release info to: Print name	Relationship	Phone number	DOB

Patient Signature OR Parent/Guardian of Minor Patient	DOB	Date

CONSENT EXCEPTION FOR TREATMENT TO A MINOR PATIENT
(14 YEARS OLD TO 18 YEARS OLD)

Your parent or legally appointed guardian has allowable access to all your medical information, healthcare concerns and diagnoses, these will be discussed without consent with the **exception** of:

I **DO** authorize the release of the below information ____
I **DO NOT** authorize the release of the following: ____

_____ Sexually transmitted diseases results (STD's)

_____ Drug, alcohol or substance abuse

_____ Pregnancy

Minor (14-18 years old) signature/ Printed name	Date