



Consent for Purposes of Treatment, Payment and Healthcare Operation

I consent to the use or disclosure of my protected health information by Robert A. Gatlin, MD for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of my by Robert A. Gatlin may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations by Nevada Women's Care. Robert A. Gatlin is not required to agree to the restrictions that I may request, however if Robert A. Gatlin agrees to a restrictions that I request, the restriction is binding on Robert A. Gatlin.

I have the right to revoke this consent, in writing, at any time, except to the extent that Robert A. Gatlin has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Nevada Women's Care Notice of Privacy Practices prior to signing this document. The Nevada Women's Care Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations for Nevada Women's Care. The Notice of Privacy Practices also describes my rights and the duties of Nevada Women's Care with respect to my protected health information.

Nevada Women's Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the office and either requesting a revised copy be mailed or available for pick up at my next appointment.

Signature of patient or guardian.

Date

Printed name of patient or guardian.