SAINT LOUIS ASSOCIATES IN OB/GYN INC
BOARD CERTIFIED IN OBSTETRICS AND GYNECOLOGY
Kent L. Snowden, M.D.

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information (PHI)
Your protected health information will be used by Saint Louis Associates in OB/GYN, Inc., or disclosed to others for the purposes of treatment, obtaining payment, or supporting daily health care operations of this practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information (PHI) may be used and/or disclosed. You may review the notice prior to signing this consent.

The Right to Restrict the Use or Disclosure of Your PHI
You may request a restriction on the use or disclosure of your protected health information.
Saint Louis Associates in OB/GYN, Inc. may or may not agree to restrict the use or disclosure of your protected health information.
If Saint Louis Associates in OB/GYN, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of Protected information in violation of an agreed upon restriction constitutes a violation of federal privacy standards.

Revocation of Consent
You may revoke this consent regarding the use and disclosure of your protected health information (PHI). This must be in writing.
Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Amend Privacy Practices
Saint Louis Associates in OB/GYN, Inc. reserves the right to modify the privacy practices outlined in this notice.
I have reviewed this consent form and give my permission to Saint Louis Associates in OB/GYN, Inc. to use and disclose my health information in accordance with it.

Billing Consent

I authorize Saint Louis Associates in OB/GYN, Inc. to release any medical or billing information, deemed necessary and/or requested by my health insurance companies, to process my claims. I assign payment of benefits for medical services to Saint Louis Associates in OB/GYN, Inc. I am responsible for all charges incurred and this is not affected by the fact that I have insurance benefits. Should my insurance company fail to pay any portion of these charges, I will be responsible for all sums owing. In addition, I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency, attorney fees, and court costs) in the event that I fail to pay my bill.
With regard to pregnancy and other health matters, I hereby authorize Saint Louis Associates in OB/GYN, Inc. to furnish a copy of my pre-natal records and/or other pertinent records to any hospital, agency, or ancillary facility deemed necessary by my physician. *If applicable*, I hereby give my permission for the providers at Saint Louis Associates in OB/GYN, Inc. to evaluate, diagnose, and treat my minor daughter as medically indicted.

_____ _____/_____/_____
Name of Patient (Please Print) Date (mm/dd/yyyy)

_____
Signature of Patient

_____ _____
Signature of Patient Representative (if applicable) Relationship of Patient Representative to Patient