LIFECYCLE WOMANCARE REGISTRATION FORM

Client DOB: SSN:

First name: Last name:

Address:

City**:** State**:** Zip:

Home Phone: Work Phone:

Cell Phone: Marital Status:
(single, married, separated, widowed, divorced, domestic partner)

Email: Race:
(White, Black/African American, Asian, Hispanic, Other)

Nickname: Other Name used at LWC?

Partners's Name: Partner's DOB:

Address:

City**:** State**:** Zip:

Home Phone: Work Phone:

Cell Phone: Partner's SSN:

Job Title/Employer:

Primary Insurance Coverage: If client has medical insurance, her coverage must be filed as primary.
(choose one)

Insurance Carrier: Client Relationship to Insured: **Self, Spouse, Child, Other**

Policy Number**:** Group Number:

Policy Holder Name: DOB:

Secondary Insurance Coverage: If client *also* has coverage under spouse, that coverage must be filed as secondary.
(choose one)

Insurance Carrier: Client Relationship to Insured: **Self, Spouse, Child, Other**

Policy Number: Group Number:

Policy Holder Name: DOB:

I, the undersigned, certify that I have given my current insurance information to Lifecycle WomanCare. I assign direct payments to Lifecycle WomanCare of all benefits paid by my insurance carrier for services rendered to myself or my dependents. I understand that I am responsible to pay all charges not covered by my insurance. I hereby authorize Lifecycle WomanCare to release all information necessary to secure the payment of benefits. This information may include a complete copy of my medical chart including all history, physical exam and laboratory data. I understand that this may include any information related to substance abuse, psychiatric care, and HIV status or testing.
This consent will remain valid as long as I have an open account at Lifecycle WomanCare. **If my insurance status changes, e.g. new carrier or loss of coverage, I will notify Lifecycle WomanCare immediately.**

Signature: Date:

Full Name _____ **Date of birth: ___/___/___ Height_____Wt_____**
(scale available in the bathroom)

What would you like to address during your appointment today?

_____

Are you currently taking any medications, drugs, over-the-counter or herbal medications, vitamins or mineral supplements? ☐ yes ☐ no If yes, list:

_____

REVIEW OF SYSTEMS:

Have you had any of the following symptoms **in the last 7 days**?

☐ Unexplained weight loss or gain of 10 lbs or more in the past year
☐ Hot flashes, night sweats or vaginal dryness
☐ Migraine OR an increase or change in headaches
☐ Painful or swollen glands in your neck, under arms or groin
☐ Nausea / vomiting
☐ Change in bowel movements
☐ Breast changes
☐ Difficulty sleeping, anxiety, depression or mood changes
☐ Pain/burning or bleeding with urination
☐ Any involuntary leaking of urine
☐ Abnormal vaginal discharge If yes, describe: _____
☐ Pain or bleeding with sexual activity
☐ Itching or irritation of genital area

Month/year of last mammogram: _____/_____ Month/year of last pap smear: _____/_____/_____
Has there been any change in your family history? (New diagnosis of diabetes, cancer …) ☐ yes ☐ no
Any change in your relationship status or new sexual partners since your last visit? ☐ yes ☐ no
How many alcoholic beverages do you drink per week (on average)? _____

Do you follow any special diet (gluten free, vegetarian etc)?_____

How often do you exercise each week? _____ What type of activity do you do?_____

MENSTRUAL HISTORY What age were you when you started your period: ___

When was the first day of your last menstrual period? _____/_____/_____

How many days from beginning of one period to the beginning of the next period? _____

Do you have problems with your period? ☐ yes ☐ no If yes, explain: _____

CONTRACEPTIVE HISTORY

What birth control methods have you used before? _____ Date stopped use? _____
Any problems with these methods? ☐ yes ☐ no If yes, explain: _____

PREGNANCY HISTORY

Number of Pregnancies	____	Vaginal deliveries	____
Abortions	____	Miscarriages	____
C-sections	____	Ectopic (tubal)	____

Are you pregnant now or is there a possibility that you are? ☐ yes ☐ no
Are you breastfeeding now? ☐ yes ☐ no
Are you planning a pregnancy in the next year? ☐ yes ☐ no

HEALTH HISTORY

Full Name: _____ **Date of birth**: ___/___/___ **Age**:_____

Ethnicity ☐African American ☐ Hispanic/Latino ☐ Native American ☐ Asian ☐ Caucasian ☐Alaskan Native ☐ Pacific Islander / Hawaiian

Currently in a relationship? ☐ yes ☐ no **If yes**, which is the best description of your relationship:
☐ dating ☐ long-term relationship ☐ religiously married ☐ legally married
☐ separated ☐ divorced ☐ widowed

Please, share the name and age of any children who live with you even part-time (adopted, foster or step children)
_____

Do you have any allergies to medications, metals, latex, rubber gloves, tape, shellfish, food or antiseptic solutions (iodine/ Hibiclens)?
☐ yes ☐ no If yes, list allergy and reaction:_____

PAST MEDICAL HISTORY
Have you **EVER** had any of the following: (please complete ***BOTH*** columns)

☐ Asthma, breathing problems, other lung disease
☐ Heart murmur or other cardiac condition
☐ Blood clot(s) in veins or lungs, blood clotting disorders
☐ Seizures or epilepsy
☐ Gall bladder removal or liver disease / tumors
☐ **Bladder, urinary tract or kidney infections**
☐ Bowel disease (e.g., IBS, Crohn's)
☐ Thyroid disease
☐ Lupus / other auto immune disorder
☐ Migraines
☐ Diabetes If yes: ☐ insulin-dependent
☐ non-insulin dependent
☐ gestational diabetes
☐ Anemia
☐ Depression, anxiety or eating disorder (specify which)
☐ Elevated blood pressure
☐ Breast cancer or other cancer - when?
_____
☐ Any history of physical, sexual or emotional abuse?
_____
☐ Herpes - If yes: ☐ oral ☐ genital
Date of last outbreak: _____

☐ Uterine abnormalities/fibroids
☐ **Chlamydia, gonorrhea, pelvic inflammatory disease (PID) or other sexual transmitted infections Including genital warts (HPV)**

☐ **Abnormal Pap smear history?** Date of abnormal _____ Have you had a colposcopy, cryotherapy, LEEP / cone biopsy? ☐no ☐ yes (**if yes**, please ***circle*** to indicate which procedure you had done)

Have you been **vaccinated** for: ☐Hepatitis B ☐Rubella
☐ Human Papillomavirus/HPV (e.g.Gardisil)
Varicella /chicken pox ☐ vaccine **or**
☐ childhood illness

Partner's History (if applicable)
Any health problems? ☐ yes _____ ☐ no
Any past or present sexually transmitted infections?
Current smoker? ☐ yes ☐ no
Any family history of inherited diseases or birth defects (on his side of the family)?

Are your or your partner of African American, Caribbean, Arab, Mediterranean, Turkish, southern Asian, Ashkenazi Jewish, French Canadian or Cajun ancestry? **Please circle any that apply.**

Please describe any serious medical problems, illness, surgeries, blood transfusions, admissions to the hospital (please provide the reason, date and length of your stay):

Any medical problems being managed by another health care provider (e.g. hypothyroidism)? If yes, explain:
_____
Name & Phone/Fax of Medical Provider managing chronic health problems:
_____

Full Name: _____ **Date of birth**: _____/_____/_____

FAMILY HISTORY (including brothers and sisters, parents or grandparents on your side of the family)

☐ I am ADOPTED or **don't know** my birth family's medical history. *(Skip to next section.)*

☐ Has anyone had a **heart attack, stroke or been diagnosed with heart disease** before the age of 55 years old? Which family member(s)**?** _____

☐ Has anyone had **high blood pressure**? Which family member(s)?_____

☐ Has anyone had ☐ **breast ☐ ovarian ☐ uterine ☐colon cancer ☐ osteoporosis**? Which family member(s)?_____

☐ Has anyone had **diabetes**? Which family member(s)?_____

☐ Have you ever been told that your **mother used DES during her pregnancy with you**?_____

☐ Any family history of **thyroid disease**? Whom? _____

☐ Any **inherited disorders** in your family? (cystic fibrosis, Tay Sachs, SMA, Fragile X …)_____

SOCIAL HISTORY

YES/NO

☐ ☐ Have you ever smoked cigarettes on a daily basis?_____

☐ ☐ Have you ever used street or IV drugs, or abused prescription drugs or other substances? _____

☐ ☐ Have you ever been physically or emotionally hurt or threatened by anyone? _____

☐ ☐ Do you have any pets? What kind? _____

What kind of work do you do? _____
How long does it take to drive to TBC from your home? _____ minutes

What is the highest level of education you achieved? ☐ GED ☐ High School graduate ☐ some college ☐ undergraduate degree ☐ postgraduate degree

Do you have smoke detectors in your house? ☐ yes ☐ no Do you always wear your seat belt? ☐ yes ☐ no
Is there a gun in your house? ☐ yes ☐ no Do you feel safe at home? ☐ yes ☐ no

SEXUAL HISTORY

☐ Are you currently in a sexual relationship? Are your partner{s) ☐ male ☐ female ☐transgender

☐ Have you **ever** felt pressured or been forced to have sex by anyone? _____

Number of partners in past year: ___ In last 60 days: ___
Does your partner(s) have other partners? ☐ no *I* unlikely ☐ not sure *I* possibly ☐yes *I* definitely
Do you use condoms *I* barriers with sex? ☐ yes ☐ no *How often?:* ☐ sometimes ☐ almost always ☐ always

Lifecycle WomanCare

NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI), also referred to as protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Executive Director, Lifecycle WomanCare, 918 County Line Road, Bryn Mawr, PA 19010, 610-525-6086 for further information.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our midwives, doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

9. Fundraising. We may contact you to request a contribution to support important activities of Lifecycle WomanCare. In connection with any fundraising, we may disclose to our fundraising staff, demographic information about you as well as the dates on which you received health care services.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- reporting of abuse, neglect or domestic violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may, in accordance with current Pennsylvania law, disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such above, neglect, or domestic violence.
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct

- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Executive Director, at Lifecycle WomanCare address on page 1, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

Highly Confidential Information. Federal and State laws require special privacy protections for certain highly confidential information about you. This includes PHI that is: 1) maintained in psychotherapy notes; 2) documentation related to mental health or developmental disabilities services; 3) drug and alcohol abuse, prevention, treatment and referral information; 4) information related to HIV status, testing, treatment as well as any information related to the treatment or diagnosis of sexually transmitted diseases; and 5) PHI related to genetic testing. Generally, we must obtain your authorization to release this type of information. However, there are limited circumstances under the law when this information may be released without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Executive Director, at Lifecycle WomanCare address on page 1. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Executive Director, at Lifecycle WomanCare address on page 1, for further information in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or

for our practice. To request an amendment, your request must be made in writing and submitted to the Executive Director, at Lifecycle WomanCare address on page 1, for further information. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Executive Director, at Lifecycle WomanCare address on page 1, for further information. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Executive Director at 610-525-6086 for further information.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Executive Director, at Lifecycle WomanCare address on page 1, for further information or to register complaints. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Executive Director at 610-525-6086 for further information.

Lifecycle WomanCare

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,_____ _____,
Patient Name D.O.B

have received a copy of Lifecycle WomanCare's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Lifecycle WomanCare

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby give my consent for Lifecycle WomanCare to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Lifecycle WomanCare's Notice of Privacy Practices provides 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. Lifecycle WomanCare 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 Lifecycle WomanCare's Privacy Officer at 918 County Line Road, Bryn Mawr, PA 19010.

- With this consent, Lifecycle WomanCare may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

- With this consent, Lifecycle WomanCare may mail to my home or other alternative location and items that assist in the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

- With this consent, Lifecycle WomanCare may email to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Lifecycle WomanCare restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

- By signing this form, I am consenting to Lifecycle WomanCare's use and disclosure of my PHI to carry out TPO.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifecycle WomanCare may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name or Legal Guardian (if applicable)

_____ _____

Print Patients Name Date of Birth