COBB WOMEN'S HEALTH

Nandita Mainthia, M.D.
F.A.C.O.G

Hitendra Hansalia, M.D.
F.A.C.O.G

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by Nandita Mainthia, M.D., and Hitendra Hansalia, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the office of Cobb Women's Health, P.A.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of Cobb Women's Health, P.A. 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, or a healthcare clearing house. This protected healthcare information relates to my past, present or future physical or mental condition and identifies me, or this is a reasonable basis to believe this information may identify me.

_____

Signature of Patient or Representative

_____

Printed name of Patient or Representative

_____

Date

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