Revision Date:

NEXTGEN MOBILE SOLUTIONS CONSENT FORM

I hereby authorize the **Capital Women's Care** Providers to use their phone to send and receive images related to my OB/GYN care via a secure, HIPAA-compliant application ("App") managed by **NextGen Mobile Solutions**. The images will be taken using the **NextGen Mobile Solutions App**, stored for a brief time on the App and not the Provider's phone, then uploaded to the NextGen EHR system which houses patient chart details.

I understand that the images captured through the App are Protected or Personal Health Information ("PHI"), and the HIPAA Privacy Rule provides federal protections for PHI held by covered entities such as Capital Women's Care and permits the disclosure of PHI needed for patient care and other important purposes.

I hereby authorize Capital Women's Care and its related entities to use the images captured via the **NextGen Mobile Solutions App** as described above. This Authorization is valid for twelve (12) months from the date of signature of this request. I understand that 1) this Authorization may be revoked by me at any time by written notification to this Capital Women's Care, except to the extent that action has been taken in reliance upon this Authorization; 2) Information released pursuant to this Authorization may be subject to re-disclosure due to a Medical Records Release request and may no longer be protected by the Federal HIPAA Privacy Rule; 3) Capital Women's Care may not condition my treatment based on whether or not I sign this Authorization; and 4) I understand that I will receive a copy of this Authorization.

PATIENT INFORMATION

Patient Name (Print): ____

Former Name (if applicable): ______________________________________

Social Security Number: ______________________

Telephone Number (Primary):____________________

Birth Date: _____/_____/______

Email Address: _________________________________

____ _____________________________________

Signature of Patient/Legal Representative **Relationship to Patient, if not signed by Patient**

____
Date

CWC Internal Use Only
Upon Completion, Upload to Patient's Chart (Document Management/ICS Tool)
Date Request was Received: ____________________
Date Request was Granted: _________________________