OB/GYN AFFILIATES
WOMENS HEALTH CARE ASSOCIATES

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, we will not leave messages on any voicemail/answering machine or with anyone other than you or your legal guardian regarding your health information with the exception of reminding you of an appointment. Please read below and consider carefully whom you want to have access to your medical information.

I, _____, give OB/GYN Affiliates my permission to discuss my medical care or leave phone messages regarding my medical care with the following people using the following contact information. I understand that medical care includes my health information, laboratory results, test results and/or financial information. I fully understand that this consent will remain valid until revoked in writing.

_____Myself at my Home / Answering Machine: #_____

_____Myself at my Cell Phone / Voice Mail: # _____

_____Myself at my Office / Work Voice Mail: # _____

OTHER:

_____Name: _____ Relationship: _____ # _____

_____Name: _____ Relationship: _____ # _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I affirm that I have received or read the HIPPA policies of OB/GYN Affiliates including the Notice of Privacy Practices. I understand that I have the right to request restrictions on the use and disclosures of my health information and that I have the right to revoke this consent in writing. I DO NOT CONSENT _____ Initials

RELEASE OF BILLING INFORMATION

I authorize OB/GYN Affiliates to release any medical information to such private insurance, the Centers for Medicate & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. I DO NOT CONSENT _____ Initials

ASSIGNMENT OF BENEFITS

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare and/or any other health plan to: OB/GYN Affiliates for any services furnished me by OB/GYN Affiliates.
I DO NOT CONSENT _____ Initials

MEDICATION HISTORY CONSENT

I authorize OB/GYN Affiliates to access and download an historic list of all medications prescribed to me by any provider over the past 13 months for the purpose of improving care and enhancing patient safety.
I DO NOT CONSENT _____ Initials

HIV TESTING CONSENT

I consent to having an HIV test ordered if I am an obstetrical patient. If I am not an obstetrical patient, I consent to having an HIV test ordered at my request or in the event that my provider feels that it is medically necessary.
I DO NOT CONSENT _____ Initials

Unless otherwise indicated above, my signature represents my consent to all of the above statements and any questions that I had have been answered to my satisfaction.

PRINT PATIENT NAME: _____

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____