ALL WOMEN
OB/GYN P.S.C.

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COMMUNICATIONS RELEASE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA)

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name _____ Date of Birth _____

SSN _____ Medical Record # _____

CONSENT FOR LEAVING MEDICAL INFORMATION ON PERSONAL PHONE

By signing this section, I am consenting to have personal medical information left on my phone. The phone number, which I feel is secure enough for this information, is _____ .

Patient Signature _____ Date Signed _____

Witness _____ Date Witnessed _____

COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

This section allows you, as the patient, to choose those persons you want to include and allow access to your medical information. This communication can be changed or voided by you at any time; however, we cannot retrieve information that has already been shared.

Please list any family members or others whom may be involved in coordinating your care. Also, please indicate what type of information may be shared with each person listed. If you are a dependent on your parents' insurance, please be aware that you must list your parent before we can release any billing/medical information to them for payment purposes.

Name (please print)	Relation to Patient	All	Appointment	Medical	Billing
_____	_____	❑	❑	❑	❑
_____	_____	❑	❑	❑	❑
_____	_____	❑	❑	❑	❑
_____	_____	❑	❑	❑	❑

When verifying identity over the phone it is our standard policy to ask questions regarding the patient's demographics (SS#, DOB, Address), or billing information. Please initial one of the following lines:

❑ I approve of the standard identity verification process
❑ I would like to use a password for identification purposes. Password: _____

All Women OB/GYN PSC will continue to rely on the information on this form when communicating with family members or others unless you request a change. To alter or void the designation above, please send a written request to the address on the top of this form.

Patient Signature _____ Date Signed _____

I hereby consent to All Women OB/GYN, PSC (the "Practice") using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's healthcare operations. I also request payment of government benefits either to myself or to the party who accepts assignments for claims.

Patient Signature _____ Printed Name of Patient/Representative _____

Date Signed _____ Relationship to Patient _____