

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE FORM)

NAME: _____ DATE OF BIRTH: _____

I authorize the release of information including my diagnosis, records, examination results, medication, lab results and claim information to the following.

NAME: _____ REALTIONSHIP _____

NAME: _____ RELATIONSHIP _____

OR

_____ **INFORMATION IS NOT TO BE RELEASED TO ANYONE OTHER THAN MYSELF**

Okay to leave detail voicemail on cell phone YES or NO

Okay to send detail email YES or NO

Patient Signature: _____ Date: _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize PrimeGYN Women’s Center and its providers/staff to view my external prescription history via eClinical Works EHR system. I understand that this may include, but not limited to, prescription history from other unaffiliated medical providers, insurance companies or pharmacies and may date back several years. I have read and understand the consent to obtain external prescription history.

Patient Signature: _____ Date: _____

PrimeGYN Women's Center
Patient registration

Patient name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Pharmacy Name and phone #: _____

Emergency contact name and phone #: _____

Race: _____ Ethnicity: _____

Insurance name: _____ **ID #:** _____

Proof of insurance is required at all appointments. If you fail to provide us with updated insurance, you will be responsible for the visit. All copays/deductibles are due in full at time of service.

Missed appointments- a \$25 fee will be assessed for all routine missed appointments and \$75 for all procedure appointments.

Account Balances- balances are to be paid in full at time of visits unless arrangements have been made with the billing department. All unpaid balances are subject to a 25% collection fee in addition to your account balance which you will be responsible for. Additional fees can also include, but not limited to, collection fees, attorney fees, and court fees.

Forms Completion- Completion of any forms such as FMLA, disability or life insurance will be billed to the patient at a fee of \$25 due at time the forms are completed.

I hereby authorize my physician to release all information acquired during my treatment/care to my insurance company. I hereby assign/authorize payment directly to the physician for medical services provided. I understand that I am financially responsible for the charges not covered/allowed by my insurance.

Patient Signature: _____ Date: _____