Please READ and fill out ENTIRE form.

Name: _____ Date: _____

Please Print

In an effort to protect each person's privacy, Associates in Women's Health and their staff are NOT allowed to give information on any patient, whether by phone or in person, without written permission from the patient. We will NOT allow persons other than yourself to receive information in person, or over the phone regarding medical records, disability forms, prescriptions, appointment date and time, etc. unless prior written permission is obtained from you, the patient.

PLEASE SPECIFY THE PEOPLE YOU ARE GIVING WRITTEN PERMISSION FOR:

- _____ Relationship: _____
- _____ Relationship: _____
- _____ Relationship: _____
- _____ Relationship: _____

- _____ YES _____ NO → Do we have your permission to call your cell phone to discuss appointments, scheduling of tests and/or procedures and results of tests/procedures?
- _____ YES _____ NO → Do we have your permission to TEXT your cell phone regarding appointments?
- _____ YES _____ NO → Do we have your permission to call your home to discuss appointments, scheduling of tests and/or procedures and results of tests/procedures?
- _____ YES _____NO → Do we have your permission to call your workplace to discuss appointments, scheduling of tests and/or procedures and results of tests/procedures?
- _____ YES _____ NO → Do we have permission to leave a message on your home/cell phone to persons other than you, or on an answering machine to please call our office?
- _____ YES _____ NO → Do we have permission to obtain/ have access to your medication history?

I have received and read the HIPAA (Health Insurance Portability Accountability Act) Notice of Privacy Practices.

Signature: _____ Date: _____

E-mail address to access our Patient Portal: _____