ELITE
WOMEN'S CARE

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1555 BARRINGTON ROAD
DOCTOR'S BUILDING I, SUITE 410
HOFFMAN ESTATES, IL 60169
PHONE: (847) 781-1894

Patient Name: _____

Disclosure Agreement Form

In order to provide the best care possible, we may contact the patient with information regarding appointments, test results, treatment plans and past due balances. Please complete the following so that we can ensure that all communication regarding your protected health information remains confidential.

Methods to contact me:

E-Mail: _____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other _____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other _____

May we leave messages on voicemail/answering machine? ____Yes ____ No

May we text you? ____Yes ____ No

May we leave message with any other person? ____Yes ____ No

IF YES, PLEASE SPECIFY:

I, _____ designate the following person(s) to speak to a physician at Susan Orhan, M.D., P.C./Elite Women's Care, APN, a nurse or other staff member on my behalf should it be necessary. I hereby give permission to Susan Orhan, M.D., P.C./Elite Women's Care through its physicians and staff, to release to my designee(s) any information about my medical condition or medical needs and I release Susan Orhan, M.D., P.C., physicians, APN, a nurse or other staff member from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: _____ Relationship: _____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other _____

AND

Name of Designated Person: _____ Relationship: _____

Phone: (_____) _____ ☐ Home ☐ Work ☐ Cell ☐ Cell Spouse ☐ Cell Mom ☐ Cell Dad
☐ Cell Other _____

Patient's Signature: _____ Date: _____/_____/_____

STD and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release: ☐ STD ☐ Drug & Alcohol

No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person/authorize above to release the information.

____/____/____	_____	____/____/____	_____
Date of Signature	Signature of patient (12 years of age or older may authorize release of STD/ Drug & Alcohol treatment information.)	Date of Signature	Signature of Parent, Legal Guardian or Authorized Representative.

Susan Orhan, M.D., P.C./Elite Women's Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-847-781-1894.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-847-781-1894.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-847-781-1894.

POS Reorder # 1823829