
**Insurance Authorization (PPO, POS, HMO and all commercial insurances)**

I hereby authorize The Association for Women's Health Care, LTD to release any medical information necessary to process insurance claims. I hereby assign The Association for Women's Health Care, LTD the benefits to which I am entitled to under my health insurance(s). I understand that I am financially responsible for all charges.

**Your insurance carrier does not assume financial responsibility for any unpaid claims**

_____ _____

Patient Signature Date

**Medicare Authorization**

I hereby authorize release of any personal health information (PHI) to or from CMS (Centers for Medicare and Medicaid Services) when necessary, in order to process my claims. I also authorize payments from my insurance programs to be made directly to The Association for Women's Health Care, LTD for any services furnished by this office. I further permit copies of this authorization to be used in place of the original.

_____ _____

Patient Signature Date

**Summary of Our Notice of Privacy Practices**

We understand that patient information is personal. We are committed to protecting the confidentiality of patient information. Our complete Notice of Privacy Practices describes how we may use and disclose your patient information without your written authorization to provide treatment, obtain payment for services, conduct our health care operations, or for other purposes that are permitted or required by law. When required by law, we will obtain your authorization before using or disclosing any of your patient information. It also describes your rights to access and control your patient information. “Patient information” is information that may identify the patient and that relates to the patient’s past, present or future physical or mental health or condition and related health care services or payments for such services.

You have the following rights regarding patient information we maintain about you:

- Right to receive a copy of our complete Notice of Privacy Practices
- Right to inspect and copy patient information in your medical or billing records
- Right to request an amendment of patient information in your medical or billing records
- Right to an accounting of certain disclosures made by us
- Right to communicate with us via alternative means or have communications sent to alternative locations
- Right to request restrictions on how we use or disclose patient information
- Right to revoke an authorization given to us

Although you have these rights, we may deny your requests if they do not meet certain requirements. If you have any questions about this Notice, your privacy rights described above or believe your rights have been violated; please contact The Association for Women's Health Care, LTD or you may file a complaint with the Director of the Office for Civil Rights of The U.S. Department of Health and Human Services.

I understand by signing this form, I give my consent for The Association for Women's Health Care, LTD to use or disclose any and all information contained in my medical record for the purpose of carrying out treatment, payment, and/or all other health care operations. I also acknowledge receipt of my physicians Notice of Privacy Practices.

_____ _____

Patient Signature Date

**Authorization To Discuss My Case**

I authorize the physicians and staff at The Association for Women's Health Care, LTD to discuss my case with the following family members or third party persons, when necessary, to expedite my care, and/or the processing of claims. I understand that I may revoke this consent by sending written notice or my desire to do so to The Association for Women's Health Care, LTD. I understand that I will not be able to do so when the physician has already relied on it to use or disclose my health information. I understand any person NOT listed will NOT receive any personal health information (PHI) about me.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship