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*Chike Obianwu, MD, MBA, FACOG, FACS*

*Shayan Khorsandi, MD*

*Jennifer Gobencion, CNM, WHNP-BC*

*Emily Johnson, MSN, CNM-BC*

*Susan Ritorto, MSN, CRNP*

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED

HEALTH INFORMATION

We are required by law to maintain the privacy of Protected Health Information.

Your signature below will allow our office to:

1. Confirm appointments at your home by phone or answering machine;
2. Disclose medical information requested by other treating physicians;
3. Leave messages or discuss medical information with your pharmacist;
4. Disclose medical information to your lab/insurance company;
5. Request medical records when necessary from physicians or health care facilities.

By signing this authorization, I authorize Alliance OB/GYN Consultants to use and/or disclose certain protected health information to the following people:

(Please print name on line provided)

Husband: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Son/Daughter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of a billing issue, do you give permission for Alliance OB/GYN Consultants/Health Claims Services (Billing Company), to discuss your bill with someone other than yourself?

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please list name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have the right to revoke or revise this authorization in writing except to the extent that Alliance OB/GYN Consultants has acted in reliance upon my authorization. My written revocation/revision must be submitted to Alliance OB/GYN Consultants, 5045 Route 130 South, Suite I, Delran, NJ 08075.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print

Signed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian Relationship to Patient

Please sign, date and print the back page