PATIENT NAME:_____ ACCOUNT#: _____

MEDICAL INFORMATION RELEASE:

Siouxland Women's Health Care, P.C. is concerned about your privacy and wants to ensure that your medical and billing information is given only to persons authorized by you. Please fill out this form so we can be sure your medical and billing information is given only to persons you wish. This may include information concerning mental health, substance abuse and HIV.

Do we have permission to:

Leave a message on your answering machine at home to contact us? ❑Yes ❑No
Leave a message at your place of employment to contact us? ❑Yes ❑No
Discuss your medical condition with any member of your household? ❑Yes ❑No

If yes, whom: _____ Relationship: _____

Do we have permission to:
Give billing information to any member of your household (besides yourself)? ❑Yes ❑No

If yes, whom: _____ Relationship: _____

Do we have permission to release information to your family physician? ❑Yes ❑No

If yes, please list family physician's name: _____

Please note **if you are a minor**, billing information will be given to your parents. If there is any circumstance where we cannot release your billing information to one of your parents, please let us know.

INSURANCE AUTHORIZATION:

I authorize Siouxland Women's Health Care, P.C. (SWHC) to release to my insurance company information needed to determine benefits for services rendered. I further request payment of authorized benefits to be made directly to SWHC.

Signature: _____ Date:_____

PRIVACY NOTICE:

By signing this form, you consent to Siouxland Women's Heath Care (SWHC) use and disclosure of personal health information about you for treatment, payment and health care operations. You have a right to revoke this consent, in writing, except where SWHC has already made disclosure in reliance of your consent. SWHC Notice of Privacy Practices is available for your review on our website at www.siouxlandwomenshealth.com, posted on the office bulletin board or you may request one of our printed policy statements.

Signature: _____ Date:_____