Patient Consent and Release Form

Yes No	**CONSENT FOR TREATMENT**: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.
Yes No	**ELECTRONIC PRESCRIBING:** I authorize Associates in Women's Health to retrieve my medication history through their e-prescribing system and then import it into my electronic medical record.
Yes No	**BILLING AUTHORIZATION**: I hereby authorize Associates in Women's Health to release requested medical information to my insurance company to collect payment for any charges incurred and acknowledge receipt of clinic credit policy.
Yes No	**ASSIGNMENT OF BENEFITS:** I hereby request that payment of insurance benefits be made directly to Associates in Women's Health on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly
Yes No	**PATIENTS' RIGHT TO PRIVACY**: I acknowledge I have been made aware of Associates in Women's Health's privacy practices, which are posted in the reception area. If I would like a copy of the HIPAA notice, I will ask for one.
Yes No	**DISCLOSURE OF PRESENCE:** I understand that during my visit my friends, family, employers or others may call to inquire about my presence at Associates in Women's Health. I authorize you to disclose information about my presence at this facility to the following people: _____
Yes No	I hereby authorize Associates in Women's Health toverbally communicate regarding my care with: Family Member/Caregiver _____ _____ **Name** **Relationship**
Yes No	**RELEASE OF MEDICAL RECORDS FOR RESEARCH:** State law requires us to inform you that your medical records may be released for research purposes unless you object. Occasionally, Associates in Women's Health receives a request for medical or scientific researchers for a copy of our patient records in order to conduct a research study. We evaluate these requests to ensure that the release of patient records is necessary to accomplish the research purpose. The researchers cannot use patient names or other identifying characteristics when reporting any results of their research. By checking the "yes" box, you authorize this release, but may also revoke this agreement at any time by notifying us in writing.
Yes No	**HEALTH NETWORK SHARING:** Your physician would like to ensure that you receive the best possible care. It is important to coordinate care amongst your primary care providers here and providers who may care for you elsewhere. When you give permission to your insurance plan to share with us that information, you help to ensure that the providers are able to care for you in the most cost effective and efficient way possible. My insurer may share my past, current and future health and account records with Associates in Women's Health about services I've received from Associates in Women's Health and other care providers unrelated to Associates in Women's Health. These records may be used by Associates in Women's Health as needed to manage or coordinate my care and to improve the quality of that care. **If I DO NOT agree to this, I will initial here _____.**

Patient Signature: _____ Date: _____