AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION:

May leave detailed message at:

☐ Home ☐ Work ☐ Cell Phone ☐ With Spouse/Partner

I authorize Seattle Obstetrics & Gynecology Group to share:

☐ ALL health care information ☐ Appointments, test results, etc.

With the following individual(s):

Name:_______________________________________ Relationship:______________________

Name:_______________________________________ Relationship:______________________

Name:_______________________________________ Relationship:______________________

DO NOT Release information to:____

Patient Initials_________

Patient Financial Responsibilities:

I acknowledge that I have read and reviewed the Financial Policy. I accept full financial responsibility for all items or services, which my insurance(s) has considered as a non-covered service. I also understand that I will be responsible for all co-pays, deductibles and coinsurance not covered by my insurance company.

Patient Initials _________

Referral Policy:

I, the undersigned, acknowledge that my insurance may require a referral or authorization before it will pay for my visit (s). If a referral or authorization is required and not received, I understand that I am responsible for the total amount of the exam, test and/or procedure.

Patient Initials_________

Acknowledgement of Notice of Privacy Practices:

Our notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices.

Print Patient Name : _______________________________ ____ Date of Birth:__________________

Signature of Patient:_________________________________ __ Date:_________________________

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