Women's Health Associates
A division of Regional Women's Health Group, LLC

HIPAA
Acknowledgements and Authorizations

Print Name:_____ Date of Birth:_____

Be advised, patients are to know their own insurances policies and benefits. This includes but is not limited to knowing lab and hospital benefits, responsibilities and affiliations, referral and prior authorization requirements.

I. Authorization for use or Disclosure of Health Information

Patient Contact Information

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.
I understand under the telephone consumer protection act, that in order for you to contact me for services relating to my medical care, including monies I may owe, I agree that Regional Women's Health Group, LLC and/or your agents may contact me by telephone, including my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented below. Methods of contact may include using prerecorded/ artificial voice messages and/or use of an automated dialing device, as applicable.

Address: _____

☐ Yes, I want to participate, my cell number is provided below.
Cell Phone Number: _____
I would like my reminders to come via Text. ☐yes ☐no

☐ No, I do not wish to participate at this time. I would prefer to be notified by:

☐ Mail ☐ Home# _____ ☐ e-mail (via the Portal – ***you will need to participate, see below***.)

Pcp:_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

I authorize messages with medical information to be left on voicemail/answering machine at: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Minors & Wives PLEASE NOTE: If your PARENT or SIGNIFICANT OTHER is not listed, we are NOT able to speak to them.

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Minors & Wives PLEASE NOTE: If your PARENT or SIGNIFICANT OTHER is not listed, we are NOT able to speak to them.

Electronic Communication

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

- ☐ Yes, I want to Participate, my email is_____
- ☐ No, I do not wish to participate at this time

Patient Signature:_____***Date:***_____***Witness:***_____