Seattle Obstetrics & Gynecology Group OB/GYN

Authorization to Release Health Care Information

I authorize Seattle OB/GYN Group to leave a detailed voicemail message at:

☐ Home ☐ Work ☐ Cell

I authorize Seattle OB/GYN Group to share:

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

With the following individual(s):

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

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: _____

Acknowledgment 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: _____