



Authorization to Release HealthCare Information

I authorize Northwest Women's Healthcare to leave a detailed voicemail message at:

Cell _____ Home _____ Work _____

I authorize Northwest Women's Healthcare to share health information with the following individuals: (eg: spouse, partner, mother, father, child, etc).

ALL health care information Appointments, test results, etc.

With the following individual(s):

Name: _____ Name: _____ Name: _____
Relationship: _____ Relationship: _____ Relationship: _____

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: (MM/DD/YY) ___/___/___

Signature of Patient: _____ Date: _____