GREECE OBSTETRICS & GYNECOLOGY, LLP

PATIENT INFORMATION, AUTHORIZATIONS & ACKNOWLEDGEMENTS

Patient's Name_____ **Maiden Name:**_____ **DOB:** _____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Telephone: (home)_____ **(cell)**_____ **(work)**_____

Married____ **Single**____ **Widow**____ **Divorced**_____

Referred By:_____

Your Occupation:_____ **Employed By:**_____

Name of Spouse:_____ **Phone:**_____ **Spouse's Employer:**_____

I authorize the release of any medical information from my physician(s) to this Practice and from the Practice to my physician(s) for continuity of care.

I authorize the release of any medical information necessary to process insurance claims and/or comply with my health plan's quality assurance reviews.

I have been offered a copy of the Notice of Privacy Practices. I can view it on your website (www.greeceobgyn.com) or request one to be emailed, faxed or mailed to me.

I understand that I am responsible for notifying the Practice if my insurance coverage changes.

CONTACTS/HIPPA

In addition to sending information via postal mail, **please circle** "Yes" or "No" to indicate how we may leave you messages regarding appointments: Home phone: Yes / No Cell phone: Yes / No Work phone: Yes / No

Emergency Contact: Name:_____ Phone:_____ Relation:_____

COMMUNICATION OF MEDICAL RECORDS:

Whom may we speak to regarding your medical care and what we can discuss:

Everything in your chart?_____ Just test results?_____ Only to make/reschedule appts?_____ Financial Information?_____

Name	Relationship	Phone	**Anything specifically we CANNOT discuss?**

Patient Signature:_____ **Today's Date:**_____