

# PATIENT AUTHORIZATIONS

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize Dr. Lori Abrams and her staff to release protected health information (PHI) included in my health record to the following individuals or entities:

### *Primary Care Physician/Other Healthcare Professionals:*

Name	Phone	Fax
_____	_____	_____
_____	_____	_____

### *Family Members/Others:*

Name	Phone	Fax
_____	_____	_____
_____	_____	_____

I understand that my medical records may contain information about but not limited to: alcohol/drug treatment, mental health, or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my PHI in accordance with the Notice of Privacy Practices. I also understand that records may be sent via telefax and I relieve Dr. Lori Abrams and her staff from any liability from mistransmission by telefax. A photocopy of this authorization shall have the same effect as the original.

**Initials** \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of a Notice of Privacy Practices brochure from Dr. Lori Abrams Gynecology. I understand that: 1) the Notice may be amended at any time, 2) notice of such amendment will be posted in the front office, and 3) I may obtain an updated brochure from the office during regular business hours.

**Initials** \_\_\_\_\_

## METHODS OF COMMUNICATION

I prefer to be contacted by the following means: (Circle all that apply and **provide numbers**)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_ US Mail \_\_\_\_\_

I understand that Dr. Lori Abrams and her staff may leave general messages with others who may receive communications at the above locations or leave messages on answering devices at these locations. General messages include appointment reminders and billing/payment reminders, NOT test/examination results or other medical or personal information.

**Initials** \_\_\_\_\_

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Lori Abrams for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance company.

**Initials** \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_