



**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
BY TELEPHONE**

I, \_\_\_\_\_, do hereby authorize Heritage OB/GYN to release information concerning my medical condition and/or medical history during telephone conversations with the following person or persons (i.e.: mother, father, husband, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I accept that Heritage OB/GYN Clinic does not have the ability to verify the identity of individuals who call requesting this information.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Our routine protocol requires that no medical information be given out over the phone without a written consent from the patient.



## PATIENT INTRODUCTION SHEET

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

HUSBAND'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_

HUSBAND'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP TO YOU \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

YOUR INSURANCE COMPANY \_\_\_\_\_

POLICY/GROUP NUMBER \_\_\_\_\_

OTHER INSURANCE (HUSBAND'S OR SECONDARY) \_\_\_\_\_

POLICY/GROUP NUMBER \_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN YOURSELF)

NAME/RELATIONSHIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DOB \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

THEIR ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP

*It is my responsibility as the patient to determine if my insurance covers evaluation and treatment by a nurse practitioner.* \_\_\_\_\_  
initial

**IN AN EFFORT TO MAINTAIN REASONABLE CHARGES,  
WE REQUEST THAT YOU PAY FOR SERVICES AT THE TIME OF EACH VISIT**

I HEREBY AUTHORIZE HERITAGE OB/GYN TO FURNISH INFORMATION CONCERNING MY TREATMENT TO INSURANCE COMPANIES AS DEEMED NECESSARY AND I HEREBY IRREVOCABLY ASSIGN TO HERITAGE OB/GYN ALL INSURANCE BENEFITS PAYABLE TO ME BY INSURANCE AND THIS AUTHORIZATION. HERITAGE OB/GYN CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING INSURANCE CLAIMS OR FOR NEGOTIATING AN INSURANCE SETTLEMENT ON A DISPUTED CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ACCOUNT.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_



I acknowledge that final responsibility for all charges in regards to my treatment rest with me. I accept responsibility for all charges to include all finance charges and in the event that HERITAGE OB/GYN is forced to utilize the services of attorneys, collection agencies, or other professional agencies to collect money on my account. I accept responsibility for all collection fees, attorney fees, finance charges and all other costs incurred in the collection process and hereby authorize those charges.

THE DOCTOR WILL TAKE A COMPLETE MEDICAL HISTORY FROM YOU; HOWEVER, PLEASE COMPLETE THE FOLLOWING INFORMATION AND FEEL FREE TO NOTE ANY OTHER INFORMATION YOU FEEL WOULD BE PERTINENT TO YOUR HEALTH.

PURPOSE OF THIS VISIT:

- PREGNANCY
- "ANNUAL" EXAMINATION
- GYNECOLOGICAL PROBLEM
- OTHER

DRUG SENSITIVITIES/ALLERGIES:

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MEDICATIONS PRESENTLY TAKING:

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PAST HOSPITALIZATIONS/SURGICAL PROCEDURES:

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OTHER:

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We reserve 5-7 days processing time for medical records.

While we make every effort to accommodate the insurance needs of our patients, it is the patient's responsibility to know if pre-certification is required or if the provider you will be seeing is covered by your insurance company.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNED