Advanced Ob-Gyn Associates., P.A.
3201 E President George Bush Hwy, # 107
Richardson, TX 75082
Ph (972) 276-9902 Fax: (972) 276-9819

Patient Authorization for Disclosure of Protected Health Information

I, _____ have read the notice of privacy practices of Advanced Ob-Gyn Associates and understand that if I have any questions I may contact the privacy manager at (972) 276-9902.

I authorize the practice to disclose or provide protected health information to me at the telephone numbers I have indicated. I understand that it is my responsibility to notify the practice of any change in these numbers and that any disclosure left on voice mail or an answering machine, indicated by me, is subject to re-disclosure statement within this authorization. How would you like us to contact you regarding testing, appointments, etc.?

Authorization to leave messages

I give my permission for the staff of Advanced Ob-Gyn Associates to give or leave messages or information regarding medication, surgery, lab results, appointments and healthcare by the following checked options. ***(PLEASE LIST TWO NUMBERS IF POSSIBLE).***

☐ My home telephone answering machine _____

☐ My email address _____

☐ My cell phone voicemail _____

☐ USPS Mailing address _____

☐ Ok to leave message on voicemail with detailed message
☐ Ok to leave message with call-back number only

Please indicate and ***PRINT*** any additional names of individuals with whom we may speak with concerning your care:

_____ _____ _____

I am authorizing the disclosure of my protected health information to the specified numbers and/or addresses as a means of enhancing communication with my healthcare provider. This authorization will **expire in one year** from the date of your signature below unless you specify an earlier termination. You must submit a new authorization after the expiration date in order to continue the authorization. As stated in the practices notice of privacy practice I have the right to revoke or terminate this authorization by submitting a written request to the privacy manager. I understand that the practice has no control regarding persons who may have access to the telephone numbers I have listed to receive my protected health information. Therefore, I understand that my protected health information disclosed under this authorization will no longer be protected by the requirements of the privacy rule and will no longer be the responsibility of the practice.

Print Patient Name _____ Patient DOB _____

Signature of Patient/Guardian _____ Today's Date _____

Authorization and Acknowledgement

I authorize Advanced Ob-Gyn Associates to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary to secure payment. I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plan to Advanced Ob-Gyn Associates. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand the financial policy set forth by Advanced Ob-Gyn Associates. I understand and agree to the terms and policy. I also understand that the terms of this financial policy may be amended by Advanced Ob-Gyn Associates at anytime with prior notification to me.

Printed Name of Patient_____ DOB _____

Signature of Patient/Guardian _____ Today's Date _____

Prescription History Consent

I voluntarily consent to provide Advanced Ob-Gyn Associates access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs and other health drug historical information) from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Advanced Ob-Gyn Associates may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Advanced Ob-Gyn Associates, unless revoked by me in writing with such written notice provided to the practice.

I certify that I have read this form or it has been read to me.

Printed Name of Patient_____ DOB _____

Signature of Patient/Guardian _____ Today's Date _____