The Colorado Women's Health Center

CONSENT FORMS

Patient (legal) name: _____ Patient DOB: _____

Patient Address: _____

Zip: _____ City: _____State: _____ Patient Soc Sec #: _____

Patient Phone #: _____ Marital Status: _____ Race: _____ Sex: F/M

E-mail address (patient portal): _____

Phone consent:

To\ protect your privacy, we have developed a policy on leaving medical information messages. We will NOT leave messages with anyone except the patient or legal guardian. Additionally, we will NOT leave confidential information on answering machines or voice mail UNLESS we have YOUR WRITTEN PERMISSION TO DO SO!!!

I, _____, give The Colorado Women's Health Center, PC permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

_____Myself on my Cell Phone / Voice Mail: #_____

OTHER:

_____Name: _____ Relationship: _____#_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I affirm that I have received or read the HIPAA policies of The Colorado Women's Health Center, PC and any questions that I had was answered to my satisfaction. I understand that I have the right to request restrictions on the use and disclosures of my health information and that I have the right to revoke this consent in writing. _____ Initials

RELEASE OF BILLING INFORMATION

I authorize The Colorado Women's Health Center, PC to release any medical information to such private insurance, the Centers for Medicare & Medicaid Services and/or any other health plan to the extent such information is needed to determine benefits or benefits payable for related services. _____ Initials

ASSIGNMENT OF BENEFITS

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, Medicare and/or any other health plan to The Colorado Women's Health Center, PC for any services furnished me by The Colorado Women's Health Center, PC. _____ Initials

MEDICATION HISTORY CONSENT

I authorize The Colorado Women's Health Center, PC to access and download an historic list of all medications prescribed to me by any provider over the past 13 months for the purpose of improving care and enhancing patient safety._____ Initials

PRINT PATIENT NAME_____

SIGNATURE OF PATIENT/GUARDIAN_____DATE: _____