Southside OB/GYN PC

Release of Information and Assignments of Benefits Declaration

(Print patient name here)

I authorize examination and medical treatment to _____. I hereby authorize all insurance benefits to be assigned to my physician. I hereby authorize the release of any medical information acquired in the course of my exam or treatment for continuity of care. I understand that I am ultimately responsible for the bill incurred by the above named patient in the event the insurance company fails to pay.

X Patient or Guardian Signature _____ Date_____

Health Information and Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1996 "HIPAA", I understand my Patient Health Information is confidential and I have the right to privacy, therefore I must sign the following release for treatment, payment and healthcare operations.

- I hereby authorize my medical information to be used or disclosed for treatment, payment or healthcare operations. I understand that I have the right to restrict and/or revoke this authorization at any time.

X Signature of Patient or Guardian _____Date_____

I have been offered a copy of Southside OB/GYN, PC's Notice of Privacy Practices:

X Signature of Patient or Guardian _____Date_____

For patients rejecting certain entities from having your personal health information, please list them.

_____

I hereby authorize you to **release** any of my Patient Health Information to the following individual:

Name of individual and relationship _____ DOB_____

example: John Doe / husband

If patient is a Minor - Minor Consent for Treatment

I, _____ do consent for my evaluation and all test result to be disclosed to my parents or custodial guardians. This consent includes but is not limited to disclosure of alcoholism, drug abuse, behavioral health, sexually transmitted disease, HIV results and abortion.

I have read and understand the above consent on this _____day of _____ in the year of_____.

_____ _____

Print patient name Printed Parent or Guardian Name

_____ _____

Patient Signature Parent or Guardian Signature

_____

Witness