metro OBGYN **Patient Name** _____ **Account #**_____

Authorization for Release of Information

Initial _____ I authorize the release of any information, including medical and billing information, by Metropolitan Obstetrics & Gynecology to my referring doctor or insurance company.

Initial _____ My insurer may share my past, current and future health and account records with Metro OBGYN about services I've received from Metro OBGYN and other care providers unrelated to Metro OBGYN. These records may be used by Metro OBGYN as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

OR ***Initial*** _____ My insurer may not release any of my identifiable health records from providers unrelated to Metro OBGYN for the purposes described above.

Initial _____ I agree that Metro OBGYN may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes

YOUR PRIMARY PHARMACY _____ _____
Pharmacy Name Pharmacy Address/Street Name Pharmacy City

Initial_____ I authorize payment of Medical Benefits, including Medicare and Medicaid benefits, be paid to Metropolitan Obstetrics & Gynecology, PA. for services rendered to myself.

Financial Policy of Metropolitan Obstetrics & Gynecology, P.A.

Charges are due and payable within 30 days upon receipt of statement. If no insurance coverage, please contact our business office to make arrangements for payment 651-265-6750.

Initial _____ I agree to pay for all services provided to me by Metropolitan Obstetrics & Gynecology PA, including those not covered by insurance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Initial _____ I am aware of Metropolitan Obstetrics & Gynecology's Notice of Privacy Practices (a copy is available upon request and is posted in the reception room).

Request for family member to have access to protected health information.

The name(s) listed below are family members and/or friends to whom I wish to grant access to my healthcare information. I hereby authorize Metro OBGYN. to disclose my Protected Health Information (PHI) including appointment and billing information to the following:

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____

□ **NONE**

Initial _____ I understand this consent will be considered valid until such time I revoke it. I may revoke this authorization by sending a written request for revocation to Metro Ob/Gyn, PA. I understand the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand and agree to these terms.

I have read each section above and initialed each appropriate section.

_____ _____ ***Effective for 1 year / or specified dates***
SIGNATURE DATE

Updated 3/29/17