Arrowhead Women's Center

PATIENT COMMUNICATION AUTHORIZATION/RELEASE OF INFORMATION

This information is for Arrowhead Women's Center for communication regarding your healthcare or billing information. We will keep this information in your medical record. PLEASE NOTIFY OUR OFFICE IMMEDIATELY OF ANY CHANGES.

Patient Legal Name: _____ Date of Birth: ____/____/_____

I authorize my personal health information to be disclosed as specified below:

Primary Number: (___)_____ Acceptable to leave a message on this number: YES NO

Secondary Number: (___)_____ Acceptable to leave a message on this number: YES NO

If you are unavailable, you authorize the following family member(s) or other person(s):

☐ Please communicate with myself ONLY

_____ / _____ / _(_____)_____
Name Relationship Phone Number

Ok to communicate ☐ Any Information ☐ Test Results ☐ Appointment Information ☐ Billing Information ☐ Other

_____ / _____ / _(_____)_____
Name Relationship Phone Number

Ok to communicate ☐ Any Information ☐ Test Results ☐ Appointment Information ☐ Billing Information ☐ Other

☐ I wish to add a password to my account. Before any information can be released regarding myself the password must be given. If I fail to provide the password, no information will be released. In the occurrence I forgot the password I placed on my account, I must show proof of ID in person to lift or change the password on my account.

The password I have chosen for my account is: _____

_____ _____
Signature of Patient/Guardian Today's Date