Account #_____

AWH
Associates in Womens Health, LLC

Authorization and Restriction of PHI

(PHI - Protected Health Information)

Patient Name:_____ **Date of Birth:** _____

Address: _____ **City/State/Zip:**_____

Cell: _____/ none **Home:** _____ **/** none / same as cell

Work: _____/ none **Email:** _____

Appointment Reminders:
On which phone may we leave messages regarding appointment information?

CIRCLE ONLY ONE text / email / voice-cell / voice-home / voice-work / do not call

Account/billing information (insurance questions, etc.):
On which phone may we leave messages regarding account/billing information?

CIRCLE ALL THAT APPLY cell / home / work / do not leave messages

Medical information (test results, prescriptions, treatment info., etc.):
On which phone may we leave messages regarding medical information?

CIRCLE ALL THAT APPLY cell / home / work / do not leave messages

Is there anyone else we may discuss your PHI with?
We will not discuss your PHI with anyone NOT listed on this form.

Name _____
Relationship _____
yes / no appt info (i.e. reschedule requests)
yes / no account/billing
yes / no medical (lab results, prescriptions, treatment info)

Name _____
Relationship _____
yes / no appt info (i.e. reschedule requests)
yes / no account/billing
yes / no medical (lab results, prescriptions, treatment info)

Is there anyone we may NOT discuss your PHI with?

Name _____
Relationship _____
yes / no appt info (i.e. reschedule requests)
yes / no account/billing
yes / no medical (lab results, prescriptions, treatment info)

Patient signature:_____ **Date:**_____