WomanCare, P.C.

Obstetrics and Gynecology

PATIENT'S AUTHORIZATION FORM

HIPAA Notice of Patient's Privacy Practices

I acknowledge receipt of ***WomanCare's*** privacy practice notice. I may request an additional copy of the privacy practice notice at any time.

Signature:_____ Date:_____

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers, including mental health providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, health insurance company and/or mental health providers.

Signature:_____ Date:_____

Consent for Rx Hub Inquiry

I hereby provide my consent to the practice of ***WomanCare, P.C.*** in order to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respects the patient's privacy. All queries and responses are made automatically through secure system-to-system communications.

Signature:_____ Date:_____