PATIENT NAME:_____ **DOB:**_____

***EMAIL ADDRESS:**_____**(this information is not released and is for our office use only to enable us to share health news and alerts)**

HIPAA/PATIENT PRIVACY

Acknowledgement of receipt of Privacy Notice and Release of Protected Health Information. I have been presented with a copy of Albany Obstetrics and Gynecology's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request that the following be adhered to regarding my Protected Health Information.

I **DO** want the following individual (s) to have access to the information checked below (ie family members, spouse) _____

_____

	YES	NO
All information		
Financial Information		
Prescription information		
Appointment information		

I wish to be contacted in the following manner (please mark all that apply):

Home phone _____ Cell phone_____ Work phone:_____		
With detailed message? _____ With call back number? _____		
Email with detailed message		

LIFETIME INSURANCE AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits are assigned for physician service to Albany Obstetrics and Gynecology. I authorize this request to apply to all services provided after the date below. I understand I am responsible for payment of any balance not paid by my insurance company as outlined in my schedule of benefits and as applicable under law.

Signature:_____Date:_____