EMERGENCY CONTACT / HIPAA POLICY

EMERGENCY CONTACTS:

________________________ ______________________ ____________________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

________________________ ______________________ ____________________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

REFERRING DOCTOR:
Were you referred to this office ________ Yes _______No

If so, by whom? ____

CONSENT OF MEDICAL RECORDS RELEASE (PHYSICIANS, ETC.)

I authorize the release of all medical records to the referring physician and/or to my insurance company, should it be requested. I permit a copy of this authorization to be used in lieu of the original.

____ _______________
(SIGNATURE) (DATE)

____ _______________
(SIGNATURE) (DATE)

CONSENT OF TREATMENT

I have received and understand Fertility & Women's Health Center of Louisiana's Notice of Privacy Policy (HIPAA). I consent to the diagnosis and treatment of me by FWHCLA.

____ _______________
(SIGNATURE) (DATE)

MEDICAL RECORDS RELEASE INFORMATION (PERSONAL)

I, _____________________________________, do hereby give my permission to release medical information to:

________________________ ______________________ ____________________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

________________________ ______________________ ____________________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)

________________________ ______________________ ____________________________
(NAME) (RELATIONSHIP) (PHONE NUMBER)