AUTHORIZATION FOR RELEASE OF INFORMATION & CONSENT TO USE & DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Seasons of Life Obstetrics & Gynecology, PC to use and disclose health information about you for treatment, payment and healthcare operations purposes. Please read completely before signing your consent.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Seasons of Life Obstetrics & Gynecology, PC to apply for benefits on my behalf. I request that payment be made directly to Seasons of Life Obstetrics & Gynecology, PC. I understand that it is my responsibility to pay any balances not paid by insurance. I understand that co-pays are due at the time of service. I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing. I understand that if my insurance company requires an authorized referral, I must present it prior to my visit. I acknowledge that if I do not provide a referral at the time of service, I will be considered a "self-pay" patient and will be responsible for the PAYMENT IN FULL for all charges incurred that day.

CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient in our practice I give consent to Seasons of Life Obstetrics & Gynecology, PC to retrieve and use my medication history from SureScripts, an electronic prescriptions network. This is an electronic way for our office to access patient prescription benefit information and patient medication history, and route prescriptions to a patient's pharmacy of choice. We can only retrieve medication history from offices who support SureScripts.

NOTICE OF PRIVACY PRACTICES

Seasons of Life Obstetrics & Gynecology, PC has a Notice of Privacy Practices which describes how we may use and disclose your protected health information and how you can access and exercise your rights concerning your personal health information. You may review our current notice prior to signing this acknowledgement and consent. Seasons of Life Obstetrics & Gynecology, PC reserves the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change.

ACKNOWLEDGEMENT & CONSENT

I have received the Notice of Privacy Practices for Seasons of Life Obstetrics & Gynecology, PC. Seasons of Life Obstetrics & Gynecology, PC is authorized to use and disclose my personal health information for treatment, payment, and healthcare operations purposes consistent with the policies stated above and its Notice of Privacy Practices.

Patient Name *(printed)*: ____

Patient/ Guardian Signature: ___________________________ Date: ___________

Relationship to Patient: ___________________________