Upstate OB-GYN Group
www.upstateobgyngroup.org

PATIENT INFORMATION: *(please print)*

Patient's Full Name: _____
Last First Middle

SSN: _____ Sex: ☐ *Female* ☐ *Male* DOB: _____

Mailing Address: _____
PO Box/Street City State/Zip

Primary Phone: _____ Secondary Phone: _____

Email: _____ Language: _____

Marital Status: ☐ *M* ☐ *S* ☐ *D* ☐ *W* **Ethnicity**: ☐ *Hispanic* ☐ *Non-Hispanic* **Race**:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Employment Status: ☐ *Full Time* ☐ *Part Time* ☐ *Retired* ☐ *Unemployed* Employer Name: _____

Responsible Party/ Guarantor: *(please print)*

Full Name: _____ Sex: ☐ *Female* ☐ *Male*
Last First

DOB: _____ SSN: _____

Mailing Address: _____
PO Box/Street City State/Zip

Primary Phone: _____ Secondary Phone: _____

Employment Status: ☐ *Full Time* ☐ *Part Time* ☐ *Retired* Employer Name: _____

INSURANCE: *(please print)*

Primary Insurance:_____ Secondary Insurance_____

Subscriber ID:_____ Subscriber ID:_____

Group Name: _____ Group Name: _____

Relationship to Insured: _____ Relationship to Insured: _____

Subscribers Name:_____ Subscribers Name:_____

Sex: ☐ *Female* ☐ *Male* DOB: _____ Sex: ☐ *Female* ☐ *Male* DOB: _____

SSN:_____ SSN:_____

Address:_____ Address:_____

Referring Physician: _____

Authorization to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. There is potential for re-disclosure. The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Notice of Privacy Practices
We are required to provide you with a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" letter provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Bon Secours Upstate OB-GYN may or may not agree to restrict the use or disclosure of your protected health information. If Bon Secours Upstate OB-GYN agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Contact Mary Nickles at (864) 271-9780 to terminate this authorization.

Reservation of Right to Change Privacy Practices
Bon Secours Upstate OB-GYN reserves the right to modify the privacy practices outlined in the notice. I understand that Bon Secours Upstate OB-GYN will notify me of these changes via the method I have authorized or upon my next appointment.

Rights of the Individual
*You may inspect or copy the information used or disclosed under this authorization by contacting Mary Nickles at (864) 271-9780.

*You may refuse to sign this authorization. If you refuse to sign, Bon Secours Upstate OB-GYN, will not deny you treatment.

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis: **If you wish a spouse, step-parent, child, secretary, friend, etc. to have access to appointment times, health information, and/or billing information, please lists them here.**

_____ **may have access to: all info billing info only diagnosis/medical info only**

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_____ **may have access to: all info billing info only diagnosis/medical info only**

2. You're billing statements and/or correspondence from our office will be sent to the address provided by you on your patient information sheet. All clinical correspondence will be marked "CONFIDENTIAL" when mailed directly from our office.

3. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are done by telephone and a brief, nonspecific message may be left on your answering machine or voicemail. The home number you provided on your patient information sheet will be used to contact you. We may also leave messages regarding treatment and/or other information pertinent to your healthcare and payment for your care provided at Bon Secours Upstate OB-GYN.

If you do not wish to be contacted in this manner, how else may we contact you?

_____

I have reviewed this consent form, received the notice entitled "Notice of Privacy Policies and Practices" and give my permission to Bon Secours Upstate OB-GYN to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print/Type) Signature of Patient OR Signature of Patient Representative **Date**

Relationship of Patient Representative to Patient

Version 1.0 Approved 07/03/2018