NORTHWESTERN OBSTETRICS & GYNECOLOGY CONSULTANTS

Patient Information

Your Physician (Please circle) Arof · Fausone · Gale · Halpern · Katz · Lukens · Mehta · Van Arsdale	Date of Appointment

Name	Previous Last Name	Social Security Number	Date of Birth

Email Address

Language	Race	Ethnicity	Gender M · F · T	Marital Status Divorced · Married · Partner · Single · Widowed · Legally Separated

Address	Unit	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Employer Information

Employer Name	Employer Address	Employer Zip Code

Pharmacy Information

Pharmacy Name	Pharmacy Phone

Pharmacy Address/Intersection	Pharmacy Zip Code

Mail Order Pharmacy Name (if applicable)

Insurance Information

Policy Holder's Name	Relationship to you	Policy Holder's Date of Birth	Policy Holder's Gender M · F

Policy Holder's Address	Policy Holder's Zip Code

Primary Care Physician Information

Physician's Name	Physician's City	Physician's Phone Number

Emergency Contact Information

Name	Relationship to you	Phone Number

Model Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I hereby give my consent to ***Northwestern Obstetrics and Gynecology Consultants, LLC*** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record _____.
(Patient name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the front desk.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it or use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

Printed: _____

If you are not the patient, please specify your relationship to the patient: _____

Optional: I give permission for _____ who is my _____ to obtain information,
Name *Relationship to you*
results, and any inquires regarding my health information, appointments, and billing information.

