Overlake
Obstetricians & Gynecologists, PC

ONLY PROPERLY COMPLETED FORMS WILL BE PROCESSED

**AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION TO ANOTHER PROVIDER, OFFICE, OR THIRD PARTY**

**Phone 425-454-3366 * Fax 425-658-5134* Email medical.records@overlakeobgyn.com**
**1231 116th Ave. NE # 950, Bellevue, WA 98004**

PATIENT NAME: _____
Last First Middle Maiden

TELEPHONE NUMBER: _____ BIRTHDATE: _____

Information to be released **FROM**: _____

Address _____
City, State, Zip Code

Phone Number _____ Fax Number _____

Information to be released **TO**: _____

Address _____
City, State, Zip Code

Phone Number _____ Fax Number _____

**PURPOSE OF RELEASE:**
[ ] Transferring Care
[ ] Moving Out of the Area
[ ] Health Insurance Change
[ ] Appointment with a Specialist
[ ] Continuing Care with PCP
[ ] Personal/Other_____

**INFORMATION TO BE RELEASED:***
[ ] the most recent 2 years of pertinent information
[ ] All Medical Records
[ ] Specific information :( Please Specify) _____
_____
_____

**Patient Authorization:**
***This authorization includes records that **MAY CONTAIN** information regarding the diagnosis or treatment of **HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment.** *Please initial if you wish to **exclude** these records.*_____***

**I UNDERSTAND THAT:**
• Authorizing the disclosure of the health information is voluntary. I do not need to sign this from in order to assure treatment or payment
• I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to OOBGYN. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
• Unless I specify differently, this authorization will expire 12 months or one year from the date of signature below.
• Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

**AUTHORIZATION/SIGNATURES**

Date:_____ Patient/Guardian Signature:_____

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# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Name (Last, First, M.I.)

Former Names (Maiden, etc.) | Preferred Name (Nickname, etc.)

Birthdate / / | Age | SSN

Marital Status (Circle one)
Single Married Divorced Widowed Separated | Driver's License # | Primary Language

Race (Circle one)
American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Caucasian Other Declined

Ethnicity (Circle one)
Hispanic/Latino Non-Hispanic/Latino Declined

Address Apt. # | City | State | Zip

Home ( ) | Work ( ) | Cell ( ) | Primary Number (Circle one) Home Work Cell

Email Personal | **Permission to access past medication history (PBM) Yes No**

Employed by | Occupation

Primary Care Physician | Referred by | **Preferred Pharmacy & Location**

Spouse's Name (Last, First, M.I.) | Birthdate / /

Employed by | Occupation

**Local Emergency Contact Name of Person *NOT* living with you** | **Relationship** | **Phone**

## AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

**You may share the following health care information with:**

Name: _____ Relationship: _____

Please check all that apply:
☐ All health care information in my medical record ☐ Insurance and billing information
☐ Health care information in my medical record relating to the following treatment: _____

**Patient agrees to photo in EMR ☐ Yes ☐ No**

**This authorization will be in effect until otherwise notified by the patient.**

- May leave detailed message on voicemail at: Home # _____ Work # _____ Cell # _____

X Signature: _____ Date: _____

## INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account.

X Signature: _____ Date: _____

I have reviewed and verified that all demographic and insurance information is correct. There are no changes at this time.

X Signature: _____ Date: _____

X Signature: _____ Date: _____

***(PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)***