Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Patient Consent/Authorization

We ask that you initial next to each number and sign this statement once you have carefully read the following information.

Thank you for your cooperation!

_____ 1. **CONSENT TO TREATMENT** I hereby voluntarily request, consent to and authorize Obstetric & Gynecology Physicians of Flint (OBGYN Physicians) and its physicians, employee(s), their associates, assistants, or other practitioners under their orders to treat me at OBGYN Physicians office, and to provide medical and surgical treatment, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. In cases of birth, this consent shall extend to my child/children. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in OBGYN Physicians office.

_____ 2. **PATIENT'S PERSONAL POSSESSIONS** OBGYN Physicians is not responsible for any patient's clothing, valuables or other personal belongings left with/by patient. I hereby release OBGYN Physicians from any liability for any and all personal possessions which I choose to keep with me during my office visit.

_____ 3. **APPOINTMENT VERIFICATION/TEST RESULTS** I understand that OBGYN Physicians of Flint contacts patients at their home to confirm appointments and/or to discuss test results. If the patient is not at home to take the call, an office associate will leave a message, if available, regarding the appointment date and time, or instructing the patient to return a call to the office.

_____ 4. **PATIENT IDENTITY VERIFICATION** I understand that lab and test results will only be released to the patient and requires verification of identity for those results to be discussed over the phone.

_____ 5. **RELEASE OF INFORMATION** I hereby authorize OBGYN Physicians, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with Federal regulations and or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. I further specifically authorize the release of information regarding: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency Related Complex (ARC) to:

(a) any third party payor, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's bill so that OBGYN Physicians may receive payment or reimbursement for the services provided to the patient.

(b) any health care facility, physician, durable medical equipment supplier or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care, and

(c) any independent auditors hired or retained by any and all third party payors, private health insurers and or any employer providing health insurance benefits to the patient, applicable to the patient's office visit, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.

(d) The release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless OBGYN Physicians has release information in reliance upon it.

Patient Name: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Obstetric & Gynecology
PHYSICIANS OF FLINT, PC

Edilberto A. Moreno, M.D. Lavanya Cherukuri, M.D., F.A.C.O.G Erin Weisler-Zatorski, PA-C

We, the providers of Obstetric & Gynecology Physicians of Flint, P.C., believe in the transfusion of blood or blood products when needed to save the lives of our patients.

_____ I, _____ ,**Consent to transfusion of blood or blood products**
(X) (Printed Patient Name)

_____ I, _____ ,**Refuse to transfusion of blood or blood products**
(X) (Printed Patient Name)

(I am aware that **if I refuse to consent** to the transfusion of blood or blood products, then **I must seek care with another provider.**)

Date:
Patient Signature

Edilberto Moreno, M.D. Date:

Lavanya Cherukuri, M.D. Date:

HIPAA Notice of Privacy Practices Acknowledgement

I understand under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge I have received or have been given the opportunity to receive a copy of your HIPAA Notice of Privacy Practices. I also understand that this practice has the right to change its HIPAA Notice of Privacy Practices, and that I may contact the practice at any time to obtain a current copy.

Date:
(Printed Patient Name) (Patient/Parent/Guardian Signature)