WOMEN'S HEALTH BOUTIQUE
HIPAA Release, Billing Release, and Medical Records Request

Patient Name: _____ DOB:_____

HIPAA Release

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print the name and relationship for each person to whom you are authorizing to release your private health care information and account balances.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I approve communications about my orders and appointments by: ____ Text _____ Email

Insurance Billing Release and Patient Responsibility of Charges

1. I hereby authorize the Women's Health Boutique to furnish my health insurance company, other third-party payers, or their designated agents with all the information which the above-named entity may request concerning treatment of the patient named above.
2. I understand that regardless of verified insurance coverage, in the event my premiums are not paid, my deductible is not met, or my insurance company denies charges, it is my financial responsibility to make payment to Women's Health Boutique.
3. _____I understand that regardless of verified insurance coverage, in the event my premiums are not paid, or my insurance company determines charges are patient liability, I am responsible for all fees for services rendered to the above patient.

Release of Medical Records

To: All my Healthcare Providers of Treatment

I _____ request that any medical records needed pertaining to claims at Women's Health Boutique be faxed to _____ or be mailed to appropriate location on cover page. I, the customer, understand that my healthcare information is to be used for treatment, payment or for healthcare operations only. I (the customer) also understand that my healthcare information may also be disclosed to other healthcare providers for the purposes of treatment, payment or for healthcare operations pertaining specifically to me.

This form expires 7 years from signature date unless patient revokes in writing this authorization.

_____ _____

Customer Signature Date