AnneMarie Spooner, M.D, F.A.C.O.G

HIPAA DISCLOSURE

Please be advised that we cannot give information to anyone without your consent below.
I give permission for Dr. Spooner and her staff to discuss any medical information with the following people:

1. _____ _____ _____
2. _____ _____ _____

Authorized person (s) Relationship to Patient Phone Number

I hereby authorize payment of all medical insurance benefits to be paid directly to the physician for services rendered. I understand and agree that I am financially responsible for charges not paid by my insurance company. I understand that in certain instances my insurance may decide that medical services are not covered, and that payment may be declined for these services. I agree to be personally and fully responsible for payment of any denied charges.

I authorize Dr. Spooner and her staff to call and/or leave messages at the following number(s) and/or email address. Messages may at times include some protected health information, including test results, appointment reminders and instructions.

Home phone: _____

Cell phone: _____

Email: _____

Patient Signature: _____

Date: _____