New Mexico Gynecology Consultants
Albuquerque, New Mexico
Tel: 505-242-5353

Patient Acknowledgements, Authorizations and Preferred Pharmacy

Patient Name _____ Date: _____
(Print) (mo/day/year)

Privacy Statement Acknowledgement

I acknowledge **New Mexico Gynecology Consultants** has provided its Notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my protected health information. If I desire, a copy of the Notice of Privacy Practices is available for me to keep. If revisions are made, I understand that it is my responsibility to request a revised copy.

Patient Initials or Signature _____

Authorization for release of Billing Information

Many patients allow family members such as their spouse, parents or others to call and request billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. Signing this form will only give consent to release this information to the following individuals indicated below and will not allow **New Mexico Gynecology Consultants** to release any other information to these individuals.

I authorize/allow **New Mexico Gynecology Consultants, PC** to discuss and release my billing information to the following individual:

Name _____ Relation to Patient _____

Patient Initials or Signature _____

Authorization to Leave Messages on Voice Mail/Answering Machine

I acknowledge that it is my right to refuse to authorize reminder calls, your lab results and other types of messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

❑	No, don't leave any messages.			
Yes, please leave me a Voice message at:		❑ Home	❑ Mobile	❑ Other
Yes, please leave me a Voice message at:		❑ Home	❑ Mobile	❑ Other

Patient Initials or Signature _____

Authorization for eMail communication & Text messaging

At **New Mexico Gynecology Consultants** our email policy is to utilize eMail and text messaging for appointment reminders, appointment recalls, billing and insurance questions, your lab results and announcements regarding our office. My signature below indicates that I agree to this email communication policy and have provided my email address(s) below. This authorization can only be revoked in writing.

❑	No, don't leave any eMail or Text messages.
Yes, please leave me eMail messages at (eMail address):	
Yes, please leave me Text messages at (Mobile Tel):	

Patient Initials or Signature _____

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Authorization for Clinical Research

Southwest Clinical Research and **New Mexico Gynecology Consultants** frequently has opportunities for clinical patients to participate in clinical trials which we conduct. One of the recruitment methods available to us is a review of prior and current clinical patient records. You can learn more about our current clinical research programs from our web site or by asking any of the office personnel. You may elect to be included or excluded in these record reviews. Please indicate your preference below:

❑	No, don't include me in Clinical Research records reviews.
Yes, please include me in Clinical Research records reviews.	

Patient Initials or Signature _____

Preferred Pharmacy

Please indicate your Pharmacy preference below:

Name of Pharmacy:	Telephone:
Address or street intersections:	