Consent to Communicate

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with William Newton/Sunflower OB/GYN. This is NOT for access to your medical records. This form, when signed, allows William Newton/Sunflower OB/GYN to communicate with the authorized person(s) regarding your personal information concerning insurance, benefits, payments, treatment or other healthcare information regarding your care.

Name:_____ DOB: _____

I hear by give my consent for Sunflower OB/GYN at William Newton Hospital to communicate personal information on my behalf to the authorized person(s) named below. This authorization allows William Newton/ Sunflower OB/GYN to speak with the authorized individual(s) regarding the following: treatment, insurance claims, copays, or other aspects of care. I understand that this is limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named. I understand that it is my responsibility to let William Newton/Sunflower OB/ GYN know of any changes or to revoke this authorization. I may revoke this authorization at any time in writing to William Newton/Sunflower OB/GYN. This authorization remains in effect for an unlimited amount of time unless revoked or updated. Any updated signed communication forms will supersede and replace all prior communication forms.

Person(s) authorized to speak with William Newton/Sunflower OB/GYN.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES- PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and/or received a copy of William Newton Hospital/Sunflower OB/ GYN's NOTICE OF PRIVACY PRACTICE.

Signature: _____ Date: _____
Relationship of representative (if applicable):

Name:_____ DOB: _____