ASHMED VÁZQUEZ MD, PC
OBSTETRICS AND GYNECOLOGY

Release of Information and Assignments of Benefits Declaration

I authorize examination and medical treatment to _____. I hereby authorize all insurance
Patient name
benefits to be assigned to my physician. I hereby authorize the release of any medical information acquired in the course of my exam or treatment for continuity of care. I understand that I am ultimately responsible for the bill incurred by the above named patient in the event the insurance company fails to pay. **We will not bill to any insurance retroactively, only the ones active on file at the time of the service.**

Patient (Guardian) Signature: _____ Date:_____

Health Information and Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I understand my Patient Health Information is confidential and I have the right to privacy, therefore I must sign the following release for treatment, payment, and healthcare operations.

I hereby authorize my medical information to be used/disclosed for treatment, payment or healthcare operations. I understand that I have the right to restrict and/or revoke this authorization at any time.

I do not want my Patient Health Information sent to the following entities: _____

_____

I hereby authorize you to release any of my Patient Health Information to the following individual:

Name: _____Relationship:_____DOB:_____

I have been offered a copy of Ashmed Vázquez MD, PC,'s Notice of Privacy Practices.

Patient (Guardian) Signature:_____Date:_____

Minor Consent for Treatment

I, _____do consent for my evaluation and all test results to be disclosed to my parents or custodial guardian. This consent includes but is not limited to disclosure of alcoholism, drug abuse, behavioral health, sexually transmitted diseases, HIV results and abortion.

I have read and understand the above consent on _____.
Date

_____ _____
Patient Name, Printed Parent or Guardian Name, Printed

_____ _____
Patient Signature Parent or Guardian Signature

_____
Witness