Pope Paul VI Institute
6901 Mercy Rd.
Omaha, NE 68106-2621

LAB ONLY

HIPAA Release & Assignment of Benefits

Thank you for choosing Pope Paul VI Institute to serve your healthcare needs! Your Privacy is very important to us. The HIPAA policy offered to you today explains how we take measures to protect your personal and medical information. Please sign this release to indicate you have been offered the HIPAA policy to review.

Contact Authorization: My preferred method of contact is

Phone _____ (Circle one: Home, Cell, Work)

Email_____

From time to time we will email or leave a message for you on an answering machine, voicemail, OR with another individual in your absence (as stated in our Notice of Privacy Practices). Please, **initial to give permission**:

_____ Leave message regarding appointment date and time (reminder calls for appointments)

_____ Leave message with provider name/phone number

_____ Leave message regarding lab/test results, medicine/treatment changes

_____ Email personal medical information

_____ DO NOT EMAIL OR LEAVE MESSAGE OF ANY KIND

MUST INITIAL if permission given to use cell phone or email:

_____ I am aware that email and cell phones are not secure or private; the information could be subject to theft or viewing by a third party.

Persons who are involved in your care (family, friends, other doctors, transportation, etc.) may inquire about your appointments, treatment, lab results, prescriptions, etc. Please let us know who we may share information with

Name _____ Relation _____ Phone_____

Name_____ Relation _____ Phone _____

Patient's Name: _____ Date of Birth_____

Signature _____ Date_____

If Patient is under 19 years of age: Printed Name of representative/guardian _____

Signature _____ Relationship _____

Assignment of Benefits: I hereby assign my insurance benefits to be paid directly to Pope Paul VI Institute Physicians PC. I authorize the release of any medical information requested by my insurance. **I understand that I am financially responsible for all charges incurred at Pope Paul VI Institute Physicians PC regardless of insurance coverage or the pendency of insurance claims.**

Signature _____Date _____

I, _____, give PPVI permission to call me on my cell phone _____

to discuss my account balance. Signature _____ PPVI Witness _____

Mailing List: The Pope Paul VI Institute occasionally sends newsletters by direct mail and/or email and these sometimes include fundraising to continue the work we do in women's healthcare. If you would like to opt-out of receiving these mailings/emails please initial here. ____