University Women's HealthCare

Main Office

☐ 401 E. Chestnut St
Suites 410, 470, 40202

☐ Continence Center
401 E Chestnut Street
Suite 460, 40202

☐ Brown Cancer Center
529 So. Jackson St 3rd Fl, 40202

University Women's HealthCare

☐ 550 South Jackson St
3rd Fl OB/GYN Clinic, 40202

☐ 3rd Fl Ultrasound Department, 40202

COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

This form allows you, as the patient, to choose those persons you want to include and allow access to your medical information. This communication can be changed or voided by you at any time; however, we cannot retrieve information that has already been shared.

Patient Name:____ DOB:______________________

SSN:____ Medical record #:_________________

Please list any family members or others who may be involved in coordinating your care. Also, please indicate what type of information may be shared with each person listed.

Name:	Relationship to Patient:	TYPE OF INFORMATION All	Appointment	Medical	Billing
______________________	__________________	☐	☐	☐	☐
______________________	__________________	☐	☐	☐	☐
______________________	__________________	☐	☐	☐	☐
______________________	__________________	☐	☐	☐	☐

When verifying identity over the phone it is our standard policy to ask questions regarding the patient's demographics, appointments or billing information. Please initial one of the lines below:

______ I approve of the standard identity verification process.

______ I would like to use a password for identity verification. Password:_________________________

University Women's HealthCare will continue to rely on the information provided on this form when communicating with family members or others unless you request a change. To alter or void the designations above, please send a written request to the address on the top of this form.

Signature of Patient/
Legal representative: ________________________________ Date: ______________________________

Relationship to Patient: ______________________________ (3/18/10)