

Associates for Women's Health
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HIPAA RELEASE OF INFORMATION

Patient Name _____ Date _____

Date of Birth _____

The following people can be given information about my health and well being:

1. Spouse _____

2. Significant Other _____

3. Any Specific Person _____

4. I may be contacted by mail regarding my health: YES or NO

5. You may leave a message on my answering machine: YES or NO

6. If you answered "yes" to question 5, at what telephone numbers may we contact you? _____

7. The following information may be given or left on answering machine:

- a. Appointment date and time
- b. Test/lab and ultrasound results
- c. Medications
- d. Procedure/referrals
- e. We may contact your employer concerning insurance denials and additional information for filing a medical claim.

Signature _____ Date _____

Witness _____ Date _____

September, 2008