



**Women's Health
Center of Reno**
GYNECOLOGY | INFERTILITY | OBSTETRICS | UROGYNECOLOGY

Patient Authorization Form

PATIENT NAME: _____

It is the policy of Women's Health Center of Reno to make confirmation phone calls to patients two days before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly.

Also, if I am not available, I authorize the staff of Samuel Chacon MD to speak with and release information to the individual(s) regarding:

Name	Relationship	Phone	Appointment		Medical/Results			Account/Billing				
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N

I authorize the staff of Samuel Chacon MD to Call my Work Number, if I am otherwise not available. Yes No

I authorize the staff of Samuel Chacon MD to leave a message on my voicemail at my work number. Yes No

Patient or Guardian Signature: _____ Date: _____