Women's Healthcare
OF EASTERN CAROLINA

# Written Acknowledgement:
# Confirming Receipt of HIPAA Privacy Notice
# Assignment & Release of Insurance Coverage
# Patient Release of Information Consent for Website

I. I have received a copy of the HIPAA Privacy Notice for Women's Healthcare of Eastern Carolina.

II. I certify that I, and/or my dependent (s), have insurance coverage with _____ and I assign directly to Women's Healthcare of Eastern Carolina all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

III. I authorize Women's Healthcare of Eastern Carolina to disclose the following information for marketing purposes. I understand that the information will be publicly displayed on the Women's Healthcare of Eastern Carolina website and no other medical information will be released.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature:_____

Child's Name: _____ Gender M or F

Child's Name: _____ Gender M or F

Patient's Printed Name: _____

Patient's Signature:_____ Date:_____

Witness: _____

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