Aurora Womancare, PC

Request for limitations and Restrictions of Protected Health Information

Name: _____ Date of Birth: _____

Which of the following communication means are appropriate/acceptable for AWC to communicate with you: (Check all that apply)

Home Phone #: leave message to return call _____ Brief _____ Detailed

Cell Phone #: leave message to return call _____ Brief _____ Detailed

Work Phone #: leave message to return call _____ Brief _____ Detailed

Who are you authorizing AWC to discuss your health information with:

No one ____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand that I may revoke this authorization in writing at any time. I also understand that this authorization is voluntary.

Acknowledgment of Financial Agreement

I hereby authorize AWC to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid. In the event that AWC has to turn my account over to collections, I understand that I will be responsible for attorney fees and court costs if legal action is necessary. I am aware of AWC's **"No Show"** policy. If I do not call at least **24 hours** prior to my appointment time to cancel, or if I fail to show up for my appointment, I will be charged a **$30.00 No Show Fee**. The No Show charge applies equally to all appointment types and insurance companies do NOT cover this fee.

Responsible Party Signature _____ Date _____