PARTNERSHIP FOR WOMEN'S HEALTH

PATIENT INFORMATION:				**CHART #**
PATIENT NAME: First Last	DATE OF BIRTH	MARITAL STATUS	HOME PHONE	
OCCUPATION	SOCIAL SECURITY NO.	DRIVERS LICENSE	CELL PHONE	
HOME STREET	CITY	STATE	ZIP CODE	
EMPLOYER NAME	EMPLOYER STREET	WORK PHONE		
EMPLOYER CITY	STATE / ZIP CODE	EMAIL ADDRESS		
SPOUSE (OR PARENT/GUARDIAN)	SPOUSE (OR PARENT) OCCUPATION	SPOUSE (OR PARENT) CELL PHONE		
SPOUSE (OR PARENT) EMPLOYER	SPOUSE (OR PARENT) EMPLOYER ADDRESS	SPOUSE (OR PARENT) WORK PHONE		
PRIMARY CARE PHYSICIAN	PHYSICIAN ADDRESS	PHYSICIAN TELEPHONE		

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS	POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE
	POLICYHOLDER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	POLICYHOLDER'S ADDRESS	WORK PHONE	POLICYHOLDER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS	POLICYHOLDER'S SOCIAL SECURITY	DATE EFFECTIVE
	POLICYHOLDER'S NAME	HOME PHONE	POLICYHOLDER'S NAME
	POLICYHOLDER'S ADDRESS	WORK PHONE	POLICYHOLDER'S DATE OF BIRTH

HOW DID YOU HEAR ABOUT US?

☐Physician: Referred by _____ ☐Website

☐Patient/Friend: Referred by _____ ☐Insurance Company

☐Other_____

BILLING TERMS AND CONDITIONS AND PATIENT AUTHORIZATION

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, unpaid balances are due within 30 days of receipt of the invoice. Accounts with balances open for more than 90 days may be charged interest on the unpaid balance at a rate of 12% per annum. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of collection including attorney's fees of 25%. **A $35 fee may be accessed for not keeping an appointment or for cancellation with less than 24 hour notice.**

I, the patient named above, hereby authorize the Partnership for Women's Health to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider. I understand that I am financially responsible for all charges whether or not I am covered by insurance.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the insurance company named above. I permit a copy of this authorization to be used in place of the original.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. As the patient or parent/guardian, I agree to the above terms and conditions.

_____ _____

Signature of Patient or Parent/Guardian Date:

PARTNERSHIP FOR WOMEN'S HEALTH

Gynecology Questionnaire

Name_____ Date of Birth* _____
Age _____ Race* _____ Ethnicity* _____ Primary Language*_____
*Required by Healthcare/Meaningful Use Legislation.
Cell Phone _____ Home Phone _____ Work Phone_____

Well Woman Update: (Please provide dates where applicable) Primary Care Provider (Doctor)_____

Last bone density exam_____ (year)
Last colonoscopy_____ (year)
Last mammogram_____ (year)
Last Pap smear_____ (month/year)
Any abnormal Pap smears? ____YES ____NO
HPV/Gardasil Vaccine series completed? ____YES ____NO
Have you had the Hepatitis B series? ____YES ____NO

Cervical Dysplasia*? _____YES_____NO
*precancerous cells of the cervix
If yes, any treatment for Cervical Dysplasia?
LEEP _____(year)
Laser _____(year)
Cryo (freezing) _____(year)
Cone Biopsy _____(year)

Medical History: Do you now have, or have you ever had:

- ☐ Asthma
- ☐ Autoimmune disorder _____
- ☐ Bleeding Disorder
- ☐ Blood transfusion
- ☐ Bone/Joint Disease
- ☐ Cancer (type?)
- ☐ Chicken pox/shingles
- ☐ Chlamydia
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Other _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Elevated cholesterol
- ☐ Endometriosis
- ☐ Fibroids (type?)
- ☐ GERD/Reflux
- ☐ G.I. illness
- ☐ Gestational Diabetes
- ☐ Gonorrhea
- ☐ Heart disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ HIV
- ☐ HPV/genital warts
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Migraines
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pelvic inflam disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Syphilis
- ☐ Trauma
- ☐ Tuberculosis

Surgical History: Please list ALL surgical procedures including year:

_____
_____
_____
_____
_____
_____

Anesthesia Complications: Check all those that apply

- ☐ Excessive difficulty waking up
- ☐ Malignant Hyperthermia
- ☐ Difficult intubation

Medicines & Allergies:
Current medications & dosage:

_____
_____
_____
_____
_____
_____
_____

Vitamins/herbal supplements _____
_____
Drug allergies _____
Reaction _____

Family History:

ILLNESS	Relationship(s)	Age(s) of Onset
Pelvic Cancer (Cervix,Uterus,Ovaries)		
Breast Cancer		
Colon Cancer		
Other Cancer_____		
Diabetes (type)		
DVT (Blood Clots)		
Heart Disease		
Osteoporosis		

Reproductive History: Menstrual Cycle

Age at first period? _____ If menopausal, age of menopause? _____

How often do you get your menstrual cycle? Every _____ days, lasting ____days

Are your cycles? ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Method of contraception:

☐ Not Needed ☐ Vasectomy ☐ Rhythm Method ☐ Mirena IUD
☐ None ☐ Tubal Ligation ☐ NuvaRing ☐ ParaGard IUD
☐ Pill ☐ Condoms ☐ Depo Provera ☐ Other_____

Obstetrical History:

Please list all types of pregnancies, including miscarriages, abortions, and ectopic pregnancies.

Type of Pregnancy: i.e. live, stillbirth, miscarriage, abortion, ectopic, molar
Type of Delivery: i.e vaginal, C/S, forceps, vacuum
Anesthesia: i.e. none, epidural, local, general, spinal
Complications: i.e. preterm labor diabetes, bleeding, high blood pressure (HBP), postpartum depression. (If preterm labor, were medications used?)

	Type of Preg.	Birthdate	Weeks	Hours of Labor	Baby's Weight	Sex	Type of Delivery	Anesthesia	Complications	Location
EX	Live	01/15/75	40	12	6lb. 2oz.	F	Vaginal	Epidural	HBP. Gest. Diabetes	West Hills

Social History:

Occupation:_____

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Same Sex Partner

Tobacco Use: ☐ Never ☐ Current # of Cigarettes per day? ____ ☐ Former, quit at age _____

Any alcohol use? ____YES ____NO *If yes, average number of drinks per week_____

Do you use street drugs? ____YES ____NO *If yes, type used and last use_____

How many times and how long per week do you exercise? (circle)

1X	2X	3X	4X	5X+
Per session	20 mins	30 mins	45 mins	60 mins+

Do you eat a healthy diet? ☐ Daily ☐ Some ☐ No

Any history of violence or abuse in your current household or in your past? _____NO _____YES

Do you have any cultural or religious considerations that need special attention? _____NO _____YES

Patient signature_____ Date: _____

Partnership for Women's Health

Obstetrics Questionnaire

Name: _____ Date of Birth: _____

Father of Baby's Name: _____

How old will you be by your due date? ____ years old

Date of first day of your last menstrual period? _____ Was it normal? ____YES ____NO

How far apart are your menstrual cycles? (days) _____

Are they regular or irregular? _____

Date of positive pregnancy test? _____

Was this pregnancy conceived on birth control pills? ____ YES ____ NO

Is this pregnancy the result of infertility treatments? ____ YES ____ NO

If so, what kind? _____

Have you had chicken pox or shingles or been vaccinated for chicken pox? ____ YES ____ NO

Do you own a cat? ____YES ____NO Do you change the litter box? ____ YES ____ NO

Are you interested in screening for birth defects and chromosomal abnormalities? ____ YES ____ NO ____ MAYBE

Do you want a blood test to determine if you carry the gene for:

Cystic Fibrosis (Caucasian and Jewish patients at highest risk)? ____ YES ____ NO

Sickle Cell Disease (African-American and Hispanic patients at highest risk)? ____ YES ____ NO

Tay Sachs Disease (Jewish patients at highest risk)? ____ YES ____ NO

Mother of the baby is the following ethnicity: (please check one or more)?

☐ Asian ☐ African-American ☐ Caucasian ☐ French-Canadian
☐ Jewish ☐ Hispanic ☐ Mediterranean ☐ Other

Father of the baby is of the following ethnicity? (Please check one or more)

☐ Asian ☐ African-American ☐ Caucasian ☐ French-Canadian
☐ Jewish ☐ Hispanic ☐ Mediterranean ☐ Other

Family history for the parents of the baby:

Disease	Mother's Family	Father's Family	Disease	Mother's Family	Father's Family
Children who died before birth or shortly after	☐	☐	Mental retardation	☐	☐
			Muscular Dystrophy	☐	☐
Cystic Fibrosis	☐	☐	Neural tube defects	☐	☐
Diabetes	☐	☐	Tay Sachs Disease	☐	☐
Downs Syndrome	☐	☐	Thalassemia	☐	☐
Hemophilia	☐	☐	Other chromosomal disorders or birth defects	☐	☐
Huntington's Chorea	☐	☐			

Patient's Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Partnership for Women's Health

Privacy Officer: Barbara Moats
7320 Woodlake Ave. Suite 280, West Hills, CA 91307, (818) 932-0728

Effective Date: April 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and/or on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their

review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other

lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to

appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Partnership for Women's Health

7320 Woodlake Ave. Suite 280, West Hills, CA 91307, (818) 932-0728

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Partnership for Women's Health's *Notice of Privacy Practices*. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment upon request.

Acknowledged and agreed to by:

Name of Patient (or Representative): _____

Signature: _____ Date: _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

For your privacy, the Partnership for Women's Health would like you to provide telephone numbers where you prefer to be contacted for any discussion of personal health information.

Please list daytime telephone number(s) at which you prefer to be reached.

Primary Phone Number: _____

Secondary Phone Number: _____

Additionally, the Federal Government now restricts the Partnership for Women's Health from discussing your health information and condition with other family members or persons unless you specifically give your written permission. If no name is provided, Partnership for Women's health will only discuss health information and condition with the patient.

By my signature below, I grant the Partnership for Women's Health permission to discuss my protected medical information with the following individuals:

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

Patient Signature: _____ Date_____

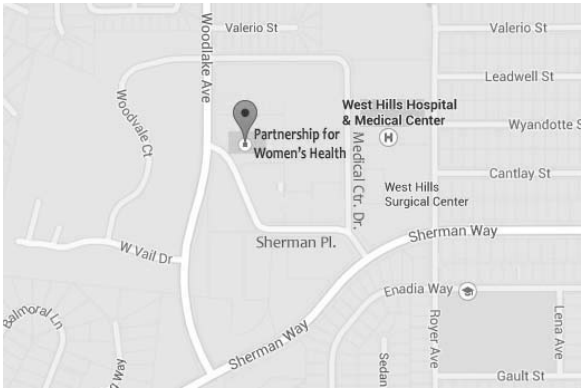
Partnership for Women's Health

DIRECTIONS

The Partnership for Women's Health is conveniently located in the West San Fernando Valley in West Hills, CA at:

7320 Woodlake Ave. Suite 280
West Hills, CA 91307
(818) 932-0728

We are located across from West Hills Hospital. See the map for details



FROM THE 118 FREEWAY

To reach us from the 118 Ronald Reagan Freeway:

- Exit on Topanga Canyon and head South.
- Turn right on Roscoe Blvd.
- Turn left on Woodlake Ave.
- We are in the three story pink building on the left at 7320 Woodlake Ave.

Entrance from Woodlake driveway

FROM THE 101 FREEWAY

To reach us from the 101 Ventura Freeway:

- Exit either Shoup Ave (if exiting from 101 N) or Fallbrook Ave (if exiting from 101 S).
- Take either Shoup or Fallbrook North to Sherman Way.
- Turn left on Sherman Way.
- Turn right on Medical Center Dr.
- Take an <u>immediate</u> left on Sherman Pl.
- Turn right on the second driveway and go up the ramp as shown in the picture.
- We are the three story pink building up the ramp at 7320 Woodlake Ave.

Entrance from Sherman Pl. driveway

Partnership for Women's Health

Obstetrics, Gynecology, and Infertility
Lauren Hyman, MD, FACOG Imelda Tio, MD, FACOG
7320 Woodlake Avenue Suite 280, West Hills, CA 91307
Phone (818) 932-0728 Fax (818) 932-9037

Authorization for Medical Records Release

Patient's Name _____ Date of Birth ____/____/____

Treatment Dates _____

Information to be released from:

Physician/Medical Group _____

Street Address _____

City _____ State _____ Zip _____

Phone Number (_____-_____-_____) Fax Number (_____-_____-_____)

Information to be released:

____ Hospital/Operative Reports
____ History & Physical Exam
____ Progress Notes
____ Other (Specify) _____
____ Lab/Radiology reports
____ Medication reports
____ ALL MEDICAL RECORDS

This authorization is effective immediately and is subject to revocation at any time. The authorization expires 90 days from the date of signing. If it has been more than 3 years since you have been seen in our office, a $25 service fee will be assessed to retrieve the file from our storage facility.

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

In addition to the above records, I consent to the release of records including those of:

Drug/Alcohol/Substance Abuse _____ (initial)
Psychiatric/Mental Health _____ (initial)
Test for Antibodies to HIV _____ (initial)
AIDS diagnosis/Treatment _____ (initial)

I further release my attending physician, consultants, the facility, and employees from any liability arising from the release of information to the person(s)/agency designated above.

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of Patient _____ Date_____/_____/_____

Signature of Parent/Guardian _____ Date_____/_____/_____