SPARTANBURG & PELHAM OB-GYN, P.A.

Patient Information **Account #** _____

Contact Information

Patient 's Name _____ Date of Birth _____

I would prefer communications from the office to be:
___ Phone ___Cell ___Home ___Email ___ Patient Portal ___ Letter

Patient Portal

We are excited to invite you to join our patient portal. The portal will allow you to communicate with your provider, view upcoming appointments and view your health information including, but not limited to lab results. Please ask the staff at check-in to send you an invite via email to activate your account.
https://myhealthrecord.com Register Email: _____

Access to Your Medical Record

Please list all persons whom we may release or discuss your medical information with. Your spouse does not automatically have access to all of your health information, so please include spouse on the list, if you want them to have access to your health information.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Telephone/ Text/ Email Messages

The staff and physicians of Spartanburg & Pelham OB-GYN, P.A., have my permission to leave all necessary messages regarding the patient listed above on voicemail, answering machine, text, or by email through a secure site. **This would only authorize us to remind you of an appointment, scheduled surgery or discuss billing matters. No detailed medical information will be given.**

Release of Medical Information

I authorize Spartanburg & Pelham OB-GYN, P.A. to release all medical records to the referring physicians and any other physician(s) who may be involved in my health care treatment, if applicable. I agree to allow my medical records to be sent by mail, fax, secure email or secure internet.

Medicare Patients Only

I authorize Spartanburg & Pelham OB-GYN, P.A. to receive direct receipt of insurance payment(s) for services rendered by the physician. I authorize my medical records to be released to The Health Care Financing Administration and its agents, whom require further determination of these benefits or befits payable for the related services, by mail, fax or secure email. _____ (initial)

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Relationship to Patient