Name: _____ DOB: _____

In an effort to better serve you, please choose the best method for **Appointment Confirmation**

Please Check One:

☐ **Phone** **Phone Number:**_____

☐ **Text** **Cell Phone:**_____

☐ **Email** **Email Address:**_____

We are now required to collect preferred language, race and ethnicity. If you prefer not to report this information you may choose to decline. Thank you for your cooperation.

Preferred Language	Race	Ethnicity
☐ English	☐ Asian	☐ Hispanic/Latino
☐ Spanish	☐ Black or African American	☐ Not Hispanic or Latino
☐ Other: _____ (Please Indicate)	☐ American Indian/Alaskan Native	☐ Decline to Report
☐ Decline to Report	☐ Pacific Islander/Native Hawaiian	
	☐ White	
	☐ Other	
	☐ Unknown	
	☐ Decline to Report	

There is an option to collect your medication refill history through your pharmacy benefit plan (if you have one). Do you consent to allow us to obtain your medication history electronically?

☐ **Yes, you may obtain my medication history.** ☐ **No, I decline to participate.**

Patient Signature: _____ Date: _____

The George Washington University Medical Faculty Associates

Acknowledgment Patient Was Provided Notice of Privacy Practices

Patient Name: _____

MRN: _____

Date: _____

I acknowledge I was given MFA's Notice of Privacy Practices today.

_____

[Patient Signature]

Witnessed by:

_____

MFA Staff Member Name:
Title:

If patient declines to sign, MFA staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgment.

_____

MFA Staff Member Name:
Title:

Name: _____

MRN: _____

DOB: _____

(Label)

Authorization for the Use & Disclosure of Protected Health Information

In accordance with HIPAA privacy laws, the GW Medical Faculty Associates ("MFA") may not use or disclose your protected health information ("PHI") without your written authorization, except as provided in our Notice of Privacy Practices. In order for MFA physicians, employees, or representatives to share your PHI with family members, friends, and/or people you choose to have knowledge of your care, you must complete this form.
****You must specifically state your spouse's name to give us authorization to communicate your PHI to them.**

I, _____ (print name) hereby authorize MFA physicians, employees, and/or representatives to share the following PHI with the person(s) listed below.

PLEASE CHECK ALL THAT APPLY:

- ☐ Test results (e.g. lab results, x-rays, biopsies, CT Scans, MRIs);
- ☐ Treatment information (e.g. discussions about prognosis, planned or current procedures, care options);
- ☐ Information pertaining to outside appointments made by our office, (e.g. the date and time of appointment, facility where testing or procedure will be done, why the appointment is being made);
- ☐ Billing issues (e.g. balance due, insurance issues)
- ☐ Other _____

☐ **DO NOT RELEASE MY PROTECTED MEDICAL INFORMATION TO ANYONE**

My protect health information may be shared with the following individual(s):

_____ (Name) _____ (Relationship) _____ (Phone #/email)

_____ (Name) _____ (Relationship) _____ (Phone #/email)

With my signature I affirm I am greater than 18 years of age and capable of giving consent. I acknowledge and understand that this authorization will be maintained in my medical record and will remain in effect until revoked by me in writing.
I understand that it is my responsibility to notify a representative of MFA if any of the above information changes.

_____ Patient Signature _____ Date

_____ Witness/MFA Representative _____ Date

You may provide a designated telephone number where messages containing PHI may be left.

☐ **Lab results and medical advice** may be left by voicemail at the following number: _____