Pt # _____
Dr #_____

Lintecum and Nickell P.C.
Obstetrics and Gynecology

Bronwyn Boyd, M.D. **Monica Franzen, M.D.** **Aubrey O'Connor, M.D.** **Joan Schieber, M.D.**

PROTECTED HEALTH INFORMATION

Please communicate with me in the following manner (**check all that apply**).

My primary contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

My secondary contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

My third contact number is: _____ Home Work Cell Other
- ❑ OK to leave a message with detailed information
- ❑ OK to leave a message with call-back number ONLY

Written Communication:
- ❑ OK to mail to my home address
- ❑ OK to e-mail: _____

My Primary Care Physician is: _____
My Primary Care Physician's Phone Number is: _____

❑ I do **NOT** have a Primary Care Physician at this time.

My Preferred Pharmacy is: _____
Pharmacy Phone Number is: _____
Pharmacy Location is: _____
(City) (State)

❑ I give permission for this office to confirm my medications with my pharmacies.

You may discuss my health care needs with the following individual(s)

Name of Individual	**Relationship to Patient**	**Phone#**
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

I understand that my primary or consulting doctor may need to request records from the physician I am seeing in the practice of Lintecum and Nickell. I also understand that my current insurance company may need to request records in order to pay for the claim that has been filed by the practice of Lintecum and Nickell. By signing this consent I am authorizing the release of those records to the physician or insurance company that is requesting them. This release expires 1 year from the date signed below.

Patient Signature: _____ **Date**: _____

Patient's Printed Name: _____ **Date of Birth**: _____