COBB WOMEN'S HEALTH

Nandita Mainthia, M.D.
F.A.C.O.G

Hitendra Hansalia, M.D.
F.A.C.O.G

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of medical information to any insurance company with whom I have medical or surgical benefits, for the purpose of filing a medical or surgical claim. I also authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of any application or claim, and for any analytical or research purposes. I also authorize this office to use my social security number for purpose of identification. **I ALSO HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO NANDITA MAINTHIA, M.D. AND HITENDRA HANSALIA, M.D.**

Patient's Signature: _____ **Date:** _____

We file to all insurances that we participate with. We will be glad to discuss our charges with you should you have any questions. **Any payment due by the patient must be paid at the time of visit.** I understand and agree that, (regardless of my insurance status); **I am ultimately responsible for the balance on my account for any professional services rendered.** I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in my health status or the above information.

Patient's Signature: _____ **Date:** _____

This office has a confidentiality policy. All services are done in this office including exams, lab work and consultations, are kept confidential. If you would like for this office to release information to ANYONE, please specify his or her name and relationship to you.

NAME: _____ **RELATIONSHIP** _____

NAME: _____ **RELATIONSHIP** _____

PATIENT'S SIGNATURE: _____ **DATE:** _____