

Southcoast Woman's Care

300 Hanover Street • Suite 2A • Fall River, Massachusetts 02720
Telephone: (508) 679-7770 • Fax: (508) 679-7786

Michelle L. Hughes, M.D., FACOG • Constance Gillett, RNC, MS

Patient Name: _____ Date: ____/____/____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

INITIAL EACH STATEMENT. SIGN AND DATE AT BOTTOM.

The providers of Southcoast Woman's Care will when necessary refer me to another provider, hospital, and/or clinic for care. I give permission to Southcoast Woman's Care to send any needed information contained in my medical record to that provider, hospital, and/or clinic.

Also, I give permission to the provider, hospital, and/or clinic to which I was referred, to send copies of any reports or results to Southcoast Woman's Care.

Initial _____

I give permission to allow my medical records to be faxed to another provider, hospital, or clinic if necessary.

Initial _____

I understand that I am responsible for payments of all services rendered to me that are in the best interest of my medical care. This includes services not covered by medical insurance carrier.

Initial _____

I give permission to Southcoast Woman's Care to leave messages on my home answering machine (if available) when I cannot be reached otherwise. Messages may be left for appointment reminders or for a call back.

Initial _____

IMPORTANT NOTE:

We are unable to return your call when you have CALL INTERCEPT or BLOCKED CALLING. Please remove these blocks or provide us with an alternate way of returning your call.

Patient Signature _____ Date: ____/____/____

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