How to Get The Most Out Of Your Doctor Visit

- When you make your appointment, let us know if you have lots of questions and concerns, or is this a well-woman visit to get a refill on your pills or hormones? This will assist us in allowing the appropriate amount of time for your visit.
- Make sure you are familiar with your insurance benefits and restrictions.
    - Does your insurance require a referral from your primary care physician (PCP) before you see another doctor? If "yes," please obtain a referral before coming to your appointment.
    - Does your plan have only certain doctors that "participate"? Is Dr. Biggerstaff on your list? Check your physician directory or call your carrier. Dr. Biggerstaff does not participate in all plans – you could be responsible for additional charges if you see a doctor who is "out of network."
    - Do you have a deductible to pay before your insurance starts paying? If so, have you met the deductible?
    - Does your plan have a set co-pay or percentage that you are responsible for? Deductibles and co-insurance are payable at the time services are rendered.
    - Be aware of specific labs, x-ray facilities, and hospitals you are to use and notify us accordingly.
    - Does your insurance require prior approval before you have any diagnostic tests, lab, etc.?
- Be aware that the cost of your visit may vary if a significant amount of extra time is needed to address your questions and concerns. Also, lab or procedures performed may increase the cost of your visit. If you have concerns about the amount you will be responsible for, please discuss with us prior to treatment being rendered.
- It may be necessary to schedule an additional appointment to allow ample time to properly meet your needs.
- Feel free to call the office to see if Dr. Biggerstaff is running on time.
- Have a list of your symptoms and concerns along with a list of questions or topics you wish to discuss.
- Please make every effort to keep your appointment and arrive on time. For the benefit of other patients, kindly advise us at least 24 hours ahead if you are unable to keep an appointment. This will allow us to work in patients who have emergencies or urgent needs while still maintaining a minimal wait time.
- Make sure you understand everything Dr. Biggerstaff and his staff say before you leave the office. Do not be afraid to take notes or ask questions.
- Feel free to call back if you get home and have a question or concern.
- We strive to continually improve our services, please let us know how we can better serve you.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Please complete this form to assist your physician in accurately maintaining your personal professional record. Please fill in all information that applies.

Title Name	First		M.I.		Last		
Address	City		State		Zip		
Home Phone	Work Phone		Alternate Phone # (Cell)		SS #		
Birthdate	Age	Sex (circle one) M F	Race	Marital Status	Spouse's Name		
Patient Employer			Patient's Occupation				
Address	City		State		Zip		

RESPONSIBLE PARTY (If other than patient)

Name/First	M.I.		Last	
Address	City		State	Zip
Home Phone	Work Phone		SS #	
Employer	Address	City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company			Relationship to Patient		Phone
Address	City		State		Zip
Insured's Name	ID #		Group #		Birthdate of Insured
Secondary Insurance Company			Relationship to Patient		Phone
Address	City		State		Zip
Insured's Name	ID #		Group #		Birthdate of Insured

Primary Care Physician		Phone	
Address	City	State	Zip
Nearest Relative (not living with you)	Relationship to Patient	Phone #	
Address	City	State	Zip
Whom may we thank for referring you?		Date	

(OVER PLEASE)

ALL PATIENTS:

1. I consent to treatment necessary for the care of the above named patient.
2. I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to the physicians involved in my medical care and to my insurance company, if applicable.
3. I permit fax transmittal of my protected health information.
4. I understand that payment of all co-pays, deductibles and services not covered by insurance is due at the time of service unless other financial arrangements have been made prior to treatment.
5. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to E. Daniel Biggerstaff, III, M.D. I fully understand that I am responsible for all charges incurred as a result of services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.
6. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATURE **DATE**

MEDICARE PATIENTS:

1. I request that payment of Medicare/Other Insurance company benefits be made either to me or on my behalf to E. Daniel Biggerstaff, III, M.D. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
2. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

SIGNATURE **DATE**

E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

Experience. Expertise. Excellence.

Please complete the following questionnaire and bring it with you to your appointment. We feel this is the best way to consistently obtain a thorough medical history. The information given will be kept in strictest confidence.

Date_____

Your full name _____ Age_____
Name you prefer we use_____
Height _____ ft. _____ in. Current weight _____lbs. Weight one year ago_____ lbs.
Weight five years ago _____lbs.
Please indicate the number of:
Pregnancies_____ Full term deliveries_____ Premature deliveries _____ Living children_____
Miscarriages_____ Pregnancy terminations_____ Ectopic pregnancies_____ Multiple births____

Please indicate the dates (when applicable) of your most recent:
Menstrual period_____ Prior menstrual period_____ Menopause_____
PAP smear_____ Cholesterol test_____ Mammogram_____ Bone density_____
Colonoscopy/sigmoidoscopy_____

Please write the **reason you made the appointment**_____
_____
What is your **main medical problem**, and how long have you had it (if none, please state so)?_____
_____
Please list **allergies to drugs or reactions to medicines or other substances**:_____
_____
_____
Please list **prior surgical operations** with the date and the surgeon if known:
_____
_____
_____
Anesthetic problems or complications:_____
_____

Social, Dietary, and Exercise History:
Do you **smoke** now?_____ In the past?_____ Amount?_____
How long have you smoked (or did you smoke)?_____ How long ago did you quit?_____
Do you drink **alcoholic beverages**?_____ Weekly amount and kind?_____
Do you use **street drugs**?_____ In the past?_____ What kind?_____

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jagyndoc@bellsouth.net

Risk factors for AIDS? Skip to Dietary History if never sexually active.
Have you ever had a positive test for AIDS?_____ Has (any of) your sexual partner(s) ever had a positive test for AIDS?_____ Have you ever had sexual relations with a bisexual? _____
Have you or your sexual partner(s):
Had more than one sexual partner in the last five years?_____ Used intravenous street drugs?_____
Received a blood transfusion prior to 1985?_____ Had sexual relations with a prostitute(s)?_____
Been exposed to AIDS through your occupation (i.e. nurse with inadvertent needle stick)?_____
Received medication to treat or prevent AIDS?_____
Other possible sexually transmitted diseases - Have you or your sexual partner(s) ever had or been treated for: Pelvic inflammatory disease?_____ Gonorrhea?_____ Syphilis?_____ Chlamydia?_____
HPV or venereal warts (condyloma)?_____ Herpes?_____
If **yes,** when was the most recent treatment or outbreak?_____

Dietary History:

How much **cholesterol** is in your diet?
_____Low (I never or rarely eat red meats, fish packed in oil, foods made with eggs and fat, whole milk and dairy products made from milk, nuts and seeds, oily dressings and spreads -- I do not eat fried foods).
_____Moderate (I eat moderate amounts of the above but not on a daily basis).
_____High (I eat much more red meat than chicken and fish, and frequently eat other high cholesterol foods).
How much **fiber** is in your diet?
_____Low (I never or rarely eat whole grain cereals, whole wheat breads, fresh fruits and vegetables -- I use highly refined grains such as white flour and their products).
_____Moderate (I eat moderate amounts of the above but not on a daily basis).
_____High (I conscientiously eat a high fiber diet and/or use a fiber supplement).
How much **sugar** do you eat?
_____Low (I do not add sugar to coffee or tea, I rarely eat desserts or sweet snacks, I do not consume alcohol on a regular basis, I do not eat highly refined grains such as white flour on a regular basis).
_____Moderate (I eat moderate amounts of the above but not on a daily basis).
_____High (I consume the above on a regular basis).
How much **seafood** is in your diet? (seafood contains Omega-3 fatty acids which help reduce cholesterol levels)
_____Low (I occasionally eat fish and other seafood, but only rarely).
_____Moderate (I eat at least two portions of seafood per week).
_____High (I eat more than two portions of seafood per week).
How much **salt** do you eat?
_____None (I do not eat any salty foods and never add salt either while cooking or at the table).
_____Minimal (I rarely eat salty foods and add only small amounts while cooking and at the table).
_____Moderate (I do not watch my salt, but do not salt my food heavily).
_____Large amounts (I consistently use large amounts of salt).

How much **caffeine** do you ingest?
_____None (no coffee, decaf coffee or tea, tea, caffeine-containing soft drinks, or chocolate).
_____Low (I only occasionally eat or drink caffeine-containing products -one cup of coffee per day).
_____Moderate (I consume two to four cups of coffee or other sources of caffeine per day).
_____Large amounts (I consume large amounts of caffeine daily).
What is your daily intake of **milk/calcium**?
_____Low (I rarely drink milk or consume dairy products, and do not take calcium supplements).
_____Moderate (I consume an equivalent of two glasses of milk per day or its calcium equivalent).
_____Large amounts (I consume at least three glasses of milk per day or its equivalent - this will provide the recommended daily amount of 1200 mg calcium).
Are you a **vegetarian**?_____ If yes, what type?_____

Physical Activity
Do you lead a **sedentary or active** life?
_____Very sedentary (no exercise, always take the elevator, do not do yard work, always ride in a car and park close to the destination, do not walk or ride a bicycle for fun, do not participate in any sports)
_____Sedentary (occasional exercise, usually take the elevator, not much work in the yard, occasionally go for a walk, etc.)
_____Active (regular exercise, regular participation in sports, regular work in the yard, regular play with children or grandchildren, frequently walk up steps rather than ride an elevator, etc.)
_____Very active (frequent exercise, regular participation in sports, usually walk up steps rather than take the elevator, always active)
How much do you **exercise**, on average, per week (formal exercise, not counting running after the children, etc.)?
_____ Medically limited - describe limitation(s) _____
_____ None
_____ Occasionally (less than regularly)
_____ Regularly (20-30 minutes, 3-4 times per week)
_____ Frequently (30-60 minutes, 4-7 times per week)
_____ Very frequently (daily for 7 or more hours per week)

Environmental Factors:
What is your occupation?_____ Education (last grade completed)?_____
What are your hobbies?_____
Do you have pets?_____
What is your source of **water supply**? _____Public with fluoride _____Public without fluoride
_____Public (do not know if have fluoride) _____Private well _____Other

What do you use for **birth control**?_____
_____Husband (partner) vasectomy?

Please list all **Current Medications** (with dosage and frequency, if known):_____
_____
_____
_____

Please check **Illnesses or Conditions** you have had:

_____High blood pressure	_____Headache/migraine
_____Heart disease	_____Sugar diabetes
_____Rheumatic fever	_____Thyroid problems
_____Heart murmur	_____Bowel problems
_____Mitral valve prolapse	_____Hepatitis or liver disease
_____Blood transfusion	_____Kidney disease
_____Phlebitis	_____Nervous or mental problems
_____Blood clot in a vein or lungs	_____Epilepsy/neurological disorder
_____Rh sensitized	_____Breast disease
_____Anemia	_____Osteoporosis/osteopenia
_____Bleeding tendencies	_____Major accidents
_____Asthma	_____Tuberculosis/positive skin test
_____Cancer	_____Emphysema

Please describe or explain any positive responses:_____
_____
_____
_____

Review of Systems -- Please check (X) ONLY if "yes":

Problems Unique to Women:

_____Do you currently have any symptoms of **vaginal problems**?

_____vaginal discharge	_____vaginal itching
_____unpleasant odor	_____vaginal dryness
_____vaginal irritation	_____difficulty lubricating with intercourse

_____Do you have or have you recently had any **abnormal bleeding**? How long?_____
_____bleeding in between periods _____excessively long periods
_____more than one period per month (even a brown, pink, or red discharge)
_____bleeding after menopause or the change (even a brown, pink, or red discharge)
_____bleeding after intercourse _____vaginal bleeding this pregnancy
_____Do you have a history of **fibroid tumors of the uterus**?

Do you currently have any **pelvic or low abdominal pain**?
_____Pain with your menstrual periods _____mild _____moderate _____severe
Does the pain start _____before your period _____at the same time _____after
_____pain when you have intercourse
_____at the entrance to the vagina _____when your partner goes in deep
_____when on your feet for long periods of time
_____history of **endometriosis** _____history of **pelvic infection**
_____other -- please describe:_____

Have you ever had an **abnormal pap smear**:_____ When?_____What was the diagnosis and treatment?_____
Did your mother take DES while pregnant with you?_____

Fertility Problems:
Have you been attempting to become pregnant for more than one year without success?_____
How long?_____ What fertility testing have you had and what were the results?
_____
_____

Have you ever had (please check) or been advised to have any **pelvic surgery**?
_____biopsy of cervix biopsy _____other biopsy (please describe)_____
_____colposcopy _____cryosurgery _____cone biopsy
_____hysteroscopy _____D&C _____tubal ligation
_____laparoscopy _____laser surgery "tubes tied"
_____removal of one or both tubes/ovaries (please describe)_____
_____
_____hysterectomy (removal of uterus or womb)
_____laparoscopic _____large abdominal incision _____removal through vagina
_____bladder repair (anterior repair)
_____rectal repair (posterior repair)
What was the reason(s) for your surgery (ies)?_____
_____

Do you currently have any symptoms possibly relating to **premenstrual syndrome (PMS)**? Symptoms are on a regular, cyclic basis, either before, during, and/or after menses. How long do they start before your period? _____days. Please check all that apply.
_____cyclic (monthly) weight gain _____bloatedness or swelling
_____mood swings _____headaches
_____vision changes _____severe breast tenderness
_____tiredness _____other (describe)_____
_____Are those symptoms severe enough for you to desire therapy to reduce or eliminate them?

_____Do you currently have any problem or question regarding your **sexual function**? If you have a problem, how long has it existed?_____
_____decreased sex drive (libido) _____difficulty becoming aroused (difficult lubrication)
_____difficulty reaching orgasm or climax _____other (describe)_____

_____Do you have any questions or problems related to the **menopause or "change"**?
_____hot flashes _____hot flashes with sweats→ _____daytime _____nighttime
_____mood swings _____fatigue and tiredness _____headaches
_____irregular bleeding _____vaginal dryness _____memory problems
_____dry skin _____other (describe)_____

_____Do you currently have any **breast problems** or have you had any surgery?
_____discharge from your breasts _____ lumps in your breasts _____breast pain
_____breast biopsy _____ mastectomy
_____augmentation _____ reduction
Have you been instructed to perform breast self-examination? _____Yes _____No
Do you examine your breasts monthly? _____Yes _____No
Have you ever had a **breast mammogram**? _____Yes _____No When?_____

Do you understand that very tiny breast cancers may not be felt by your doctor, and that is why repeat examinations are necessary? _____Yes _____No
Do you understand that mammograms are very helpful, but that not all breast cancers can be seen on X-Ray? _____Yes _____No

_____Do you or have you had **urinary tract problems**?
_____bladder infection(s) or cystitis
How many in the last year?_____ Last one when?_____
_____kidney infection(s)
_____other urinary tract disease (describe):_____
_____burning or pain on urination
_____frequency of urination
_____need to urinate during the night -- how many times?_____
_____loss of urine with coughing, sneezing, running, lifting or straining
_____feeling you cannot make it to the bathroom
_____is the loss of urine a significant problem?
_____other urinary tract problems (describe):_____

_____Do you currently have **gastrointestinal problems**?
_____constipation _____diarrhea _____constipation and diarrhea
_____rectal pain or pressure _____rectal itching _____rectal bleeding or blood in the stool
_____regular use of laxatives _____hemorrhoids
_____difficulty having a bowel movement so that you have to put a finger in the vagina to assist
_____other (describe):_____

_____Do you currently have **constitutional symptoms**?
_____fever or chills
_____weight gain _____lbs. in _____months weight loss _____lbs. in _____months
_____tiredness
_____difficulty getting to sleep _____difficulty staying asleep

_____Do you currently have **skin and hair problems**?
_____complexion problems _____dry skin
_____recent change in size or color of nevus (mole) -- Where?_____
_____increased hair growth (chin, lip, etc.) _____Does this run in your family?
_____hair loss

Do you have ANY OTHER MEDICAL PROBLEMS that are not covered in this questionnaire? If so, please list:_____
_____
_____
_____
_____

Past Pregnancies:

Delivery Date	Weeks Gestation	Length Labor	Vaginal or C-section	Type of Anesthesia	Sex	Birth Weight	Remarks

Family History: (includes father of the baby if pregnant or anticipating pregnancy)
Do any family members have (had) the following (please indicate which relative or relatives):

_____endometriosis_____
_____breast cancer_____
_____ovarian cancer_____
_____uterine cancer_____
_____colon cancer_____
_____high blood pressure_____
_____heart disease_____
_____stroke_____
_____osteoporosis_____
_____sugar diabetes_____
_____thyroid disease_____
_____AIDS_____
_____mental retardation_____
_____epilepsy_____
_____neural tube defect (including spina bifida)_____
_____Down's syndrome_____
_____Tay Sach's_____
_____Sickle cell_____
_____Muscular dystrophy_____
_____Huntington's chorea_____
_____hemophilia_____
_____cystic fibrosis_____
_____other birth defects_____
_____multiple pregnancy losses_____
_____multiple pregnancies (twins, etc.)_____
_____Tuberculosis_____

	Living	Age or age at death	Present health or cause of death
Father	_____Yes _____No	_____	_____
Mother	_____Yes _____No	_____	_____

Brothers' and sisters' other medical problems: _____
_____
Children's other medical problems:
_____
_____
Other relatives' other medical problems:_____
_____

Religious and Ethnic Background:_____
(Certain diseases may run in families of certain religious or ethnic background).

I have noted or listed all medical problems or conditions that I am aware of in the above questionnaire.

I have provided complete information concerning medical problems or conditions of which I am aware.

Signature_____ Date_____

ADVANCED HEALTHCARE FOR WOMEN FINANCIAL POLICY

COPAYS The patient is expected to present the current insurance card at each visit. All co-pays and any previous balance are due at the time of service.

SELF-PAY ACCOUNTS Self-pay accounts are patients who are covered by insurance plans that the practice does not participate in, patients without an active insurance card on file, or at the time of service, have not met their deductible. Payment is required at the time of service for all services including lab, procedures, exams and surgeries.

EXTENDED PAYMENT ARRANGEMENTS If charges exceed those estimated in advance or if insurance payments are less than estimated in advance, any remaining balance is to paid in three equal payments within 90 days of the service date. Patients who fail to meet their financial obligation are subject to collection proceedings and may be released as a patient from the practice.

NONPARTICIPATING INSURANCE PLANS The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. The insurance company will be billed as a non-assigned claim as a courtesy to the patient. The patient will be responsible for charges in full at the time of service. The insurance company should reimburse the patient direct for any monies due. If the check is sent to the practice, the patient will be sent a refund in a timely manner.

AUTOMOBILE ACCIDENT CASES The patient will be treated as a self-pay account unless a subrogation agreement is provided by health insurance. If a subrogation agreement is provided and the physician participates with the insurance carrier, the health insurance is billed. If an attorney is involved in the case, a letter of protection will be obtained whether an insurance company is involved or not.

PATIENT REFUNDS The following criteria must be met prior to a patient refund being issued: There are no outstanding patient balances on the account and there are no outstanding insurance claims on the account.

DIVORCE CASES In cases of divorce where the spouse may be responsible for medical bills, the patient is expected to pay at the time of service. The practice will not bill a divorced spouse for the patient's services.

CHILD CUSTODY CASES AND TREATMENT OF MINOR CHILDREN The parent accompanying the child at the time of her appointment will be responsible for payment at the time of service. The practice will bill any insurance carried on the child. The practice will not get involved in any split payments, etc. set up by the court system, etc.

This financial policy allows us to focus on rendering quality care to our valued patients. If you have any questions or need clarification of any of the specific policies, we encourage you to ask a member of our staff.

_____ _____

Patient Signature Date

E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

Experience. Expertise. Excellence.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and State law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

_____

SIGNATURE **DATE**

RELATIONSHIP TO PATIENT

E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my health care, Advanced Healthcare for Women originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the healthcare professionals who contribute to my care
- A source of information of applying my diagnoses and treatment to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as quality assessments and physician certifications

I understand and have been provided with a copy of your Privacy Practices, which gives a more complete description of uses and disclosures of my health information. I have been given the opportunity to review the notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests. I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action relying on this consent. I further understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and **ACCEPT** the terms of this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

E. DANIEL BIGGERSTAFF, III, M.D.

ADVANCED HEALTHCARE FOR WOMEN

Experience. Expertise. Excellence.

Patient Authorization for Use or Disclosure of Protected Health Information

I authorize the release or disclosure of the protected health information as described below:

Name of Patient_____ Date of Birth_____

Name and Address of Person/Organization releasing information:
_____
_____
_____
_____

Name and Address of Person/Organization receiving information:
_____
_____
_____
_____

I authorize the following information to be disclosed:

[ ] Copies of the patient's medical records for the period ___/___/___ to ___/___/___

[ ] Copies of information described below for the period ___/___/___ to ___/___/___
Medical Data/Information as related to:
[ ] Specific condition(s): _____
[ ] Specific professional service(s): _____
[ ] Specific medication(s): _____
[ ] Other: _____

[ ] Other: _____
_____

Purpose(s) of disclosure:
_____
_____

Candler Professional Building, Suite 518

5354 Reynolds St., Savannah, Georgia 31405

912.355.7717 fax 912.355.0979

www.womensdoctor.com

OVER PLEASE

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

- History of acquired immunodeficiency syndrome (AIDS)
- Sexually transmitted disease
- Human immunodeficiency virus (HIV)
- Behavioral health services/psychiatric care
- Treatment for alcohol and/or drug abuse or similar conditions

I understand that there is the potential for redisclosure of the protected health information by the recipient and that Advanced Healthcare for Women assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Advanced Healthcare for Women from all legal liability that may arise from this authorization.

The patient or the patient's representative may revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Advanced Healthcare for Women must receive the revocation in writing. The revocation must include:

- The patient's name, address, and patient number, if applicable,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Advanced Healthcare for Women will accept written revocations of this authorization via:

[X] Certified U.S. mail
[X] Facsimile at this number: 912/355-0979

ALL revocations must be sent to Advanced Healthcare for Women to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

This authorization shall expire on _____. After this date, Advanced Healthcare For Women can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

If signature is not that of patient, I am acting on behalf of the patient because: _____
_____

_____ _____
Relationship to patient Witness