



Southern Colorado Maternal Fetal Medicine

6071 E. Woodmen Road, Suite 440
 Colorado Springs, CO 80923
 (719) 622-3442

PATIENT REGISTRATION FORM (PLEASE PRINT)

Name _____ Maiden Name _____ Marital Status: M S O

Address _____ City _____ State _____ Zip _____

Cell# _____ Home# _____ Work# _____

DOB _____ SSN# _____ Referred By _____

Pharmacy _____ Location _____

Race: Decline White Asian American Indian / Alaska Native Black / African American Nat Hawaiian / Pacific Islander Other

Ethnicity: Decline Hispanic or Latino Not Hispanic or Latino

Emergency Contact (Required) _____ Phone# _____

Relationship to Patient _____

Person responsible for payment if patient is a Minor _____ DOB _____

SSN# _____ Address _____ Phone# _____

INFORMATION AUTHORIZATION RELEASE CONSENT

Southern Colorado Maternal Fetal Medicine is in accordance with the Federal Laws to the fullest extent. HIPPA is the privacy act that protects patient medical information from being disclosed to anyone for any reason without written consent from the patient. The form below will allow us to release information about you, the patient, to individual(s) who are non-medical in relation to you. This consent form can be changed by patient at anytime and for any reason. This form is valid for one year from the date it was signed.

Please indicate phone number(s) where Southern Colorado Maternal Fetal Medicine may leave voice messages. _____

Chose one option below

Option 1 **Authorizing Patient Information to be Released**

Authorized Individuals
 These individual(s) have been selected by the patient listed above.

1) _____ Relation _____

2) _____ Relation _____

Patient Signature _____ Date _____

Option 2 **Authorizing Patient Information NOT to be Released**

By signing this section below, you are choosing **NOT** to release **ANY** of the above infromation to ANY individual(s) other than yourself. This means that spouses, children, parents, family members, etc. cannot access any information regarding your care at SCMFM. I am aware that SCMFM privacy and office policies are available in the Southern Colorado Maternal Fetal Medicine office.

Patient Signature _____ Date _____