PATIENT AUTHORIZATION

Sinai Hospital of Baltimore Faculty Practice Providers are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize the Sinai Institute for Female Pelvic Medicine (Urogynecology) to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.

2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.

3. Call my home or work and leave a message to contact the office. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.

4. Update my personal demographic information either on the phone or in the office at the time of my appointment.

5. At my request, I give permission to discuss my personal health with the designated person(s) below:

______________________________	______________________________
Name	*Relationship*
______________________________	______________________________
Name	*Relationship*
______________________________	______________________________
Name	*Relationship*

I have read and agree to the above policies.

____________________________________	________________________
Patient Name (print)	*Date*

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Signature of Patient