

Patient Name \_\_\_\_\_

Thank you for choosing Jefferson Center for Women's Medical Specialties for your care.

We know that your time is valuable. In order to make your first visit as smooth as possible, we ask that you please complete the enclosed medical history and registration forms. **Please bring all forms with you for your appointment.** Please **DO NOT** mail completed forms to the office prior to your appointment. Additional information may be enclosed, please complete.

At each visit in our office, our receptionists will ask you to review your registration information and verify that it is correct. We do ask that you bring your insurance card with you to **every visit and be prepared to pay any co-pay that is your responsibility.**

If you are coming for a consultation or a second opinion, you should bring any pertinent records related to your condition (i.e. radiology reports, surgical reports, etc.).

You have scheduled an appointment with:

- |   |   |
|---|---|
| <input type="checkbox"/> Jay Goldberg, MD   | <input type="checkbox"/> Adebola Nnewihe, MD          |
| <input type="checkbox"/> Aileen Gariepy, MD | <input type="checkbox"/> Sarah Rosen, MD              |
| <input type="checkbox"/> Colleen Horan, MD  | <input type="checkbox"/> Carmen Sultana, MD           |
| <input type="checkbox"/> Cheung Kim, MD     | <input type="checkbox"/> Abigail Wolf, MD             |
| <input type="checkbox"/> Thomas Klein, MD   | <input type="checkbox"/> Monica Choi, CRNP, PhD       |
| <input type="checkbox"/> Dennis Lorell, MD  | <input type="checkbox"/> Lisa Goetz-Spitko, CRNP, MSN |

Date of Appointment \_\_\_\_\_

Time of Appointment \_\_\_\_\_

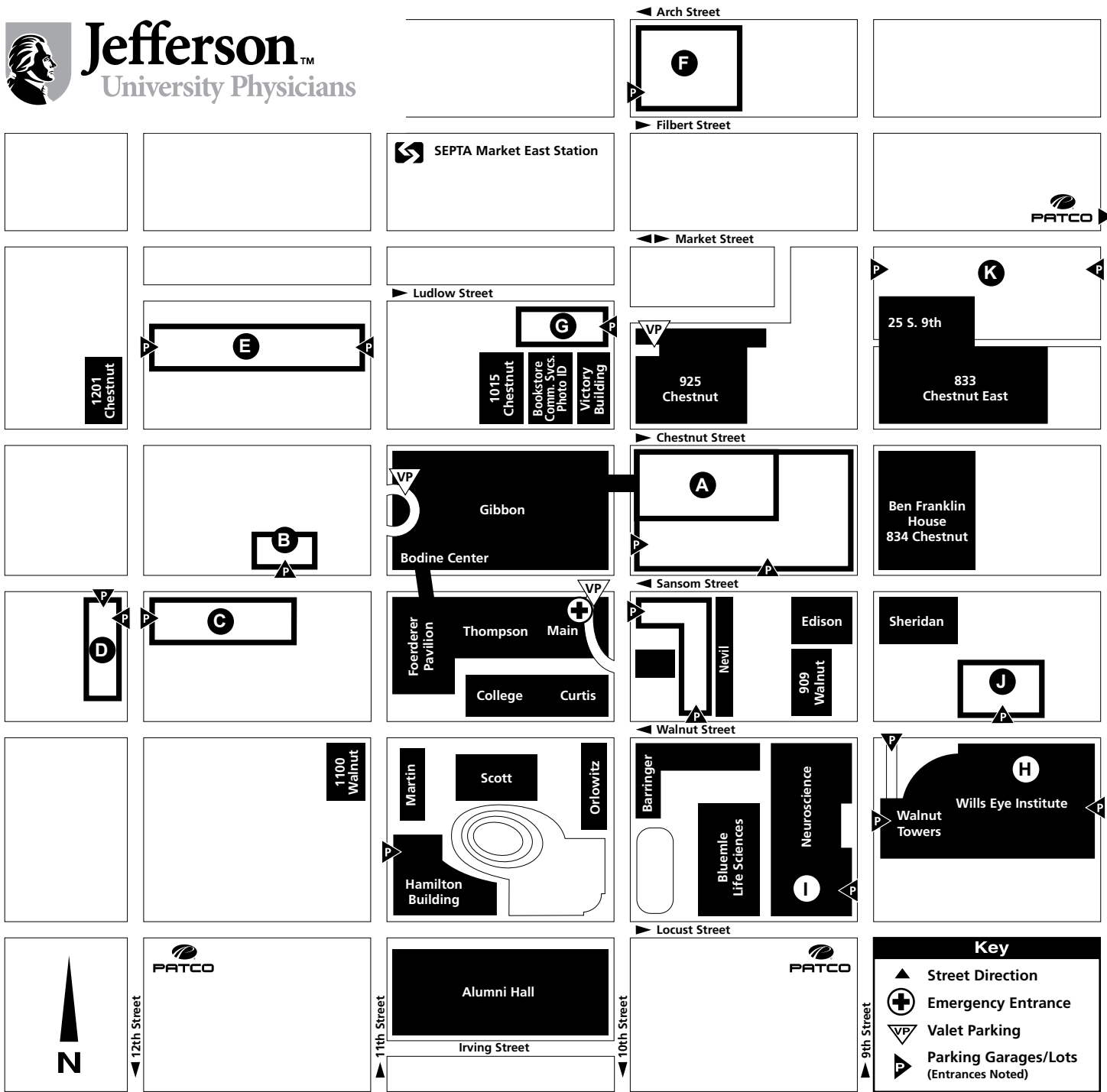
## Office Location:

834 Chestnut Street, Suite 300  
Philadelphia, PA 19107  
215-955-5000

If you are not able to keep your appointment, we ask that you call our office to cancel so that we may offer this appointment to another patient. **Please be advised, we allow a 15 minute grace period for lateness for appointments. If you arrive more than 15 minutes after your scheduled appointment time, you MAY BE asked to reschedule your appointment.**

Sincerely,

The Physicians of Women's Medical Specialties



**A. 10th & Chestnut St. Garage**

Entrances on 10th St. and on Sansom St.

**B. Central Parking System (Eglin)**

Open lot between 11th and 12th on Sansom St.

**C. Central Parking System (Eglin)**

12th and Sansom St.

**D. Alright Parking Garage**

12th St. between Sansom and Walnut Sts

**E. Girard Square Parking**

1120 Clover St., between Chestnut and Ludlow Sts.

**F. The Auto Park at Gallery Mall**

10th St. between Arch and Filbert Sts.

**G. Philadelphia Parking Authority Garage**

10th and Ludlow Sts.

**H. Wills Eye Hospital–Walnut Towers Garage**

8th and 9th Sts. between Locust and Walnut Sts.

**I. Jefferson Hospital for Neuroscience Garage**

8th and 9th Sts. between Locust and Walnut Sts.

**J. Walnut Street Theater Lot**

819 Walnut St.

**K. Central Parking System**

Open lot between 8th and 9th Streets on Market St.

# Directions

## **From Pennsylvania Turnpike**

Exit at Valley Forge. Take Rt. 76 East to I-676 East to the 8th Street/Chinatown Exit. Take 8th Street to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

## **From I-95 North of Wilmington**

Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

## **From I-95 South (from Bucks County)**

Take Exit 22 Independence Hall/Callowhill Street. Turn right onto Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

## **From New Jersey Shore Points**

Take the Atlantic City Expressway North to Rt. 42 North. Follow signs for Ben Franklin Bridge. Cross over

Ben Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

## **From Central New Jersey**

Rts. 70 West and 38 West will take you to the Ben Franklin Bridge. Cross over Ben Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

## **From New York**

Take the New Jersey Turnpike South to Exit 4/Rt. 73 North. Take Rt. 73 North to Rt. 38 West. Follow Rt. 38 West to the Ben Franklin Bridge. Cross over Ben Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left into 8th Street and follow it to Walnut Street. Turn right onto Walnut Street, then make another right onto 9th Street. The Ben Franklin House will be on your right, about 1 1/2 blocks. Parking is on the left across from the building. You will also pass many other areas to park.

Account No.	Entered Date
Reg. By	Office Site

## JUP Patient Registration Form

Please complete this form in order to ensure proper billing of your services. **Please Print.**

**Today's Date:** \_\_\_\_\_

Patient Name: _____ Last Name	Social Security Number: _____
First Name: _____ MI	Date of Birth: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Other Name: _____	Race: ( <b>Response is not mandatory. Data is used for statistical reporting.</b> )
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Daytime Phone: (_____) _____
City, State, Zip: _____	
Home E-mail: _____	Home Fax: (_____) _____
Employer: _____	Emp Status: <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time
Addr1: _____	<input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker
Addr2: _____	<input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other _____
City, St, Zip: _____	Work Phone (_____) _____

**Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)**

Guarantor: _____	Patient's Relationship to Guarantor: _____
Addr1: _____	Social Security Number: _____
Addr2: _____	Date of Birth: _____
City, St, Zip: _____	Sex: _____
_____	Home Phone: (_____) _____
_____	Work Phone: (_____) _____
Employer: _____	
Addr1: _____	
Addr2: _____	
City, St, Zip: _____	

Emerg Cont: _____	Patient's Relationship to Emerg Cont: _____
Addr1: _____	Home Phone: (_____) _____
Addr2: _____	Work Phone: (_____) _____
City, St, Zip: _____	

How did you hear of our practice?  Billboard  Brochure  Health Fair  Health Plan  Internet  Jeff NOW®  Mass Mailing  
 Newspaper/Mag.  Ongoing Care  Other  Patient  Phone Bk  Phys. Off./ER  Relative  Radio  TV  Word of Mouth

**Insurance Information**

**A separate form is required for workers' compensation, automobile liability, or legal services.**

PRIMARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____
SECONDARY CARRIER: _____	
Address: _____	Telephone #: (_____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

**Primary Care Physician / Referring Physician**

PCP: _____	Refer. Phys. (if different): _____
Addr: _____	Addr: _____
City, St, Zip: _____	City, St, Zip: _____
Telephone #: _____	Telephone #: _____

Jefferson Center for Women's Medical Specialties  
**Medical History Questionnaire**

Page 1

Name		Date
Birthdate	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep	Social Security

**I am here today for**


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**Family/Primary Care Physician/Internist**


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Name

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Address

---

Phone Number

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**Do you see any specialists?**       Yes    No

Name	Name
Address	Address
Phone Number	Phone Number

**Who referred you to our practice?**     Primary Care Physician     Other

**Pregnancy History**

Age at first pregnancy

Year of Pregnancy	Miscarriage	Abortion	Ectopic Pregnancy	Vaginal Delivery	Cesarean Delivery	Girl	Boy	Weight	Wks Preg At Deliv.	Problems

Name	Date
------	------

**Family History**

List anyone in your family (parents, grandparents, siblings or children) who had/have

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Breast disease/cancer	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> Strokes, Blood Clots
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> High Blood Fats (Cholesterol, lipids, etc.)
<input type="checkbox"/> <input type="checkbox"/> Heart Attack before age 50	<input type="checkbox"/> <input type="checkbox"/> Colon Cancer
<input type="checkbox"/> <input type="checkbox"/> Other Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> <input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> <input type="checkbox"/> Other Cancers
<input type="checkbox"/> <input type="checkbox"/> Endometrial Cancer	<input type="checkbox"/> <input type="checkbox"/> Lung Disease
<input type="checkbox"/> <input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/> Anemias	<input type="checkbox"/> <input type="checkbox"/> Birth defects/Genetic Problems/Traits
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease	

<b>Father</b> <input type="checkbox"/> living <input type="checkbox"/> deceased Cause of death	<b>Mother</b> <input type="checkbox"/> living <input type="checkbox"/> deceased Cause of death
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I am adopted – birth family history unknown

**Personal History**

Have you ever had

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Vaginal Infections (Yeast, bacterial)
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Diseases (syphilis, gonorrhea, genital herpes, chlamydia, trichomons, genital warts, etc.)
<input type="checkbox"/> <input type="checkbox"/> Visual Problems not corrected by glasses such as blurred or double vision	<input type="checkbox"/> <input type="checkbox"/> Infections of uterus, tubes, ovaries, PID
<input type="checkbox"/> <input type="checkbox"/> Headaches (frequent/severe) migraines/dizzy	<input type="checkbox"/> <input type="checkbox"/> Other problem with uterus/tubes (i.e., fibroids, cysts, etc.)
<input type="checkbox"/> <input type="checkbox"/> Epilepsy, convulsions, fainting	<input type="checkbox"/> <input type="checkbox"/> Abnormal pap smear
<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Pain or bleeding with sex
<input type="checkbox"/> <input type="checkbox"/> Hormonal problems, abnormal hair growth	<input type="checkbox"/> <input type="checkbox"/> Psychiatric/Emotional Problems
<input type="checkbox"/> <input type="checkbox"/> Acne	<input type="checkbox"/> <input type="checkbox"/> Mental Depression
<input type="checkbox"/> <input type="checkbox"/> Lung problems (tuberculosis, asthma, bronchitis)	<input type="checkbox"/> <input type="checkbox"/> German measles/rubella
<input type="checkbox"/> <input type="checkbox"/> Liver Disease (hepatitis, mono, jaundice)	<input type="checkbox"/> <input type="checkbox"/> Chicken Pox/varicella
<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Murmurs/Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Measles/rubeola
<input type="checkbox"/> <input type="checkbox"/> Strokes/Blood Clots (legs/lungs)	<input type="checkbox"/> <input type="checkbox"/> Did your mother take DES while pregnant with you?
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Do you smoke? How much?
<input type="checkbox"/> <input type="checkbox"/> Blood Problems	<input type="checkbox"/> <input type="checkbox"/> Alcohol use? _____ per week
<input type="checkbox"/> <input type="checkbox"/> High Blood Fats (cholesterol, lipids, etc.)	<input type="checkbox"/> <input type="checkbox"/> Drug use? Type and Frequency?
<input type="checkbox"/> <input type="checkbox"/> Fluid retention, especially feet or ankles	<input type="checkbox"/> <input type="checkbox"/> IV drugs?
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease (infections, cysts, stones)	<input type="checkbox"/> <input type="checkbox"/> Blood Transfusions?
<input type="checkbox"/> <input type="checkbox"/> Loss of Urine	<input type="checkbox"/> <input type="checkbox"/> Exercise?
<input type="checkbox"/> <input type="checkbox"/> Pain or Bleeding with Urination	<input type="checkbox"/> <input type="checkbox"/> Do you use seat belts in the car?
<input type="checkbox"/> <input type="checkbox"/> Gall Bladder Disease/Stones	<input type="checkbox"/> <input type="checkbox"/> Have you had Choleaterol Screening? Date of last screen?
<input type="checkbox"/> <input type="checkbox"/> Stomach or Bowel Pain or Problems	<input type="checkbox"/> <input type="checkbox"/> Have you ever had a relationship in which there was physical, sexual or psychological abuse?
<input type="checkbox"/> <input type="checkbox"/> Breast Problems (lumps, tumors, cysts, nipple discharge, cancer)	<input type="checkbox"/> <input type="checkbox"/> Do you regularly do self breast exams?
<input type="checkbox"/> <input type="checkbox"/> Have you had a mammogram? Date of last mammogram?	<input type="checkbox"/> <input type="checkbox"/> Surgery: Type and Year

Jefferson Center for Women's Medical Specialties  
**Medical History Questionnaire** Page 3

Name	Date
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Yes    No   Hospitalizations? Why and When  
 \_\_\_\_\_  
 \_\_\_\_\_

How would you rate your health now?    Good    Fair    Poor

**Allergies**

Do you have any medication allergies?    Yes    No

Medication	Reaction

**List any allergies to foods, metals or other substances**

\_\_\_\_\_

\_\_\_\_\_

**Medications**

Are you currently taking any medication?    Yes    No   If yes, list:

Medication	Dosage	Reason for Taking

**Menstrual History**

Age of First menses	First day of last menstrual period	Periods come every _____ days	Number of Days of flow
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Are your periods:    light    moderate    heavy    clots

Yes    No   Was this period normal?

Yes    No   Do you think you may be pregnant now?

Yes    No   Do you ever miss periods?

Yes    No   Do you ever bleed between periods?

<input type="checkbox"/> Yes <input type="checkbox"/> No   Do you take medication for pain?	Name of medication
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Yes    No   If you are menopausal, have you had bleeding?

Name	Date
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**Sexual and Contraceptive History**

Age of first intercourse

Number of partners since first intercourse

Number of partners last year?

Partners  Male  Female  BothAre you using birth control now?  Yes  NoDo you plan children in the future?  Yes  No  Undecided

If you and your partner want birth control, what method do you want?

Are you satisfied with your current contraceptive method?

- I am interested in HIV Testing/Information
- I would like to be screened for STD's (gonorrhea, chlamydia, syphilis, hepatitis)
- Do you have any questions about sex you'd like to discuss?

**Please check all methods used by you or partner**

	Type	Date Used
<input type="checkbox"/> Pills		
<input type="checkbox"/> IUD/Coil		
<input type="checkbox"/> Diaphragm		
<input type="checkbox"/> Tubal ligation		
<input type="checkbox"/> Vasectomy		
<input type="checkbox"/> Other		

**Contraceptive Method Problems**

Pill	IUD	Diaphragm
<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual vaginal bleeding
<input type="checkbox"/> Yes <input type="checkbox"/> No Blurred, double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No Unusual vaginal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Discomfort
<input type="checkbox"/> Yes <input type="checkbox"/> No Pain, swelling of legs	<input type="checkbox"/> Yes <input type="checkbox"/> No Fever or chills	<input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Tract infections
<input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain	
<input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal Pain		
<input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice		
<input type="checkbox"/> Yes <input type="checkbox"/> No Severe depression		

**Exam /Pap/Problems** Yes  No Do you have symptoms of infection (itching, burning, discharge)?

Date of last pap

Result

Dear Patient:

As you know, infection with HIV (the virus that causes AIDS) is an increasingly serious danger for American women. Unfortunately, many people do not know they are infected, because they have no symptoms. Pregnant women can pass the virus to their unborn, babies, but we now know that treatment of the mother can often prevent this from happening.

For this reason, and so that any complications in the mother can be treated immediately, we strongly recommend HIV testing for all pregnant women. However, please understand that HIV testing (a blood test that can be done at the same time as your other routine tests) is entirely voluntary. The results will be provided for you and kept in your confidential medical record. If you would like more information before making this important decision, let us know and we will arrange detailed counseling.

We ask that you complete and sign the attached questionnaire, which is voluntary and confidential. It is intended to help us in advising you, and it indicates your decision in regard to HIV testing.

Thank you,

Jefferson Center for Women's Medical Specialties

# HIV Testing Questionnaire

Name (Please Print)

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1. Have you ever had a blood transfusion? If yes, was it before or after 1985?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Before <input type="checkbox"/> After
2. Have you ever been treated for a sexually transmitted disease? (gonorrhea, chlamydia, syphilis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever used street drugs by injection? (shooting up)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had sexual relations with a partner who ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
5. Have you had sexual relations with a partner who ever used drugs by injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
6. Have you ever had sexual relations with a man who ever had sex with other men?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
7. Have you ever had sexual relations with a partner who might have been at high-risk for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
8. Do you think that you are at risk at all for being HIV infected?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please check one of the following:**

- I would like to be HIV tested.
- I need to think more about HIV testing.
- I do not want to be HIV tested.
- I would like to meet formally with an HIV educator before deciding.
- I have chosen not to complete this questionnaire.

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Signature

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Date

## Jefferson Center for Women's Medical Specialties

# Prenatal Genetic Screen

Patient Name	MR #	Date
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1. **Will you be 35 years of age or older when the baby is due?**  Yes  No
2. **Have you, the baby's father or anyone in either of your families ever had any of the following disorders?**
- **Down Syndrome (mongolism)**  Yes  No
  - **Other chromosomal abnormality**  Yes  No
  - **Neural tube defect, e.g. spina bifida (meningomyelocele or open spine), anencephaly**  Yes  No
  - **Muscular dystrophy**  Yes  No
  - **Cystic fibrosis**  Yes  No

If yes, indicate the relationship of the affected person to you or the baby's father:

Any other disorders not listed?

3. **Do you or the baby's father have a birth defect?**  Yes  No
4. **In any previous pregnancy, have you or the baby's father had a child born dead or alive with a birth defect not listed in #2 above?**  Yes  No

If yes, what was the defect and who had it?

5. **Do you or the baby's father have any close relatives with mental retardation?**  Yes  No

If yes, indicate the relationship of the affected person to you or the baby's father:

Indicate the cause, if known

6. **In any previous pregnancy, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous miscarriages?**  Yes  No

Have either of you had a chromosomal study?  Yes  No

If yes, indicate who, the results, and where done

7. **If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?**  Yes  No

If yes, indicate who and the results

8. **If you or the baby's father are black, have either of you been screened for sickle cell trait?**  Yes  No

If yes, indicate who and the results

9. **If you or the baby's father are of Italian, Greek or Mediterranean background, have either of you been tested for Beta-thalassemia?**  Yes  No

If yes, indicate who and the results

10. **If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for Alpha-thalassemia?**  Yes  No

11. **Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include non-prescription drugs)**  Yes  No

If yes, give name of medication and time taken during pregnancy

I have discussed with my doctor the above questions which are answered "Yes" and understand the importance and availability of genetic counseling. I  DO /  DO NOT wish to avail myself of this opportunity to obtain genetic counseling.

Signature	Date
Witness	Date

Dear Patient:

The staff of Women's Medical Specialties will be glad to help you with the completion of various forms that may be necessary to assist you with your healthcare. For example:

**Disability Forms**  
**FMLA Forms**  
**Insurance Forms**

You will be charged \$10.00 for each form that is submitted to our office. Cash or check will be accepted.

This \$10.00 fee is not a cost covered by insurance. This charge is totally separate from any co-pay or coinsurance and will be expected prior to your receipt of the completed form(s). Forms will not be completed and returned until the fee is paid.

We appreciate your understanding and thank you in advance for your cooperation.

Sincerely,

Jefferson Center for Women's Medical Specialties

THOMAS JEFFERSON UNIVERSITY

Jefferson University Physicians

*Communication of Protected Health Information*

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**Part A:**

You have informed Jefferson University Physicians (JUP) that in certain circumstances, you would like us to share your medical information with specified individuals (e.g., your spouse, mother, etc.).

JUP agrees to communicate with persons whom you designate regarding your protected health information. This agreement will remain in effect unless you provide us with written notice to terminate this consent.

**Part B:**

I hereby grant Jefferson University Physician's department/division of \_\_\_\_\_ permission to communicate my protected health information to the following individuals:

Name	Address	Telephone #	Patient Relationship

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Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_