Healthy Woman
Obstetrics Gynecology

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# Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman OBGYN to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered. Listing a designated person(s) I will not make that person responsible for payment.

_____ _____
Name of Designated Person Relationship to patient

_____ _____
Name of Designated Person Relationship to patient

☐ I DO NOT wish to designate any person(s)*

*Please note for children under 18 years of age, information will be released to the parent or legal guardian.

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) for the purpose of my treatment.

_____
Name of Designated physician/facility Type

_____ _____
Name of Designated physician/facility Type

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

- ☐ I DO wish to have messages left at (___)_____
- ☐ I DO NOT wish to have messages left at (___)_____
- ☐ I DO NOT wish to have email sent to _____

I understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

X _____ _____/_____/_____
Patient Signature DATE
Print name: _____