

Patient _____ Patient DOB _____

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to The OB-GYN Place, P.A. to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name Relationship

Name Relationship

Name Relationship

_____ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact (Please **INITIAL** all that apply)

_____ OK to leave a message on my HOME PHONE with detailed information. PH# _____

_____ Leave a message on my home phone with a call-back number only.

_____ OK to leave a message on my CELL PHONE with detailed information. PH# _____

_____ Leave a message on my Cell phone with a call-back number only.

_____ OK to leave a message on my WORK PHONE with detailed information. PH# _____

_____ Leave a message on my work phone with a call-back number only.

_____ OK to mail to my home address _____

_____ OK to mail to my work/office address _____

_____ OK to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient/ or Legal Representative

Date

