Patient_________________________________ Patient DOB______________________

Patient Preference Regarding Communication of Health Information

<u>Who to Contact</u>

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).

<u>How to Contact</u> (Please <u>INITIAL</u> all that apply)

_____OK to leave a message on my HOME PHONE with detailed information.

_____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

_____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.

_____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/Parent/or Legal Representative Date