Authorization to Share Medical Information

Chart #:_____

I, _____ , DOB __/__/____ , authorize OB-GYN, P.C. to share my:

- ☐ Personal and/or demographic information.
- ☐ Medical information - excluding _____.
- ☐ Billing/financial/insurance information to include diagnosis and procedure codes for my visit.
- ☐ All information.
- ☐ **I do not wish to share information with anyone**.

To the following individuals:

Name	Relationship to patient
_____	_____
_____	_____

Purpose of Disclosure:

- ☐ Surgical procedure
- ☐ Pregnancy
- ☐ Other
- ☐ At patient request

This authorization will remain in effect for one year or unless revoked in writing by the above listed patient.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to the address below: Attn: Privacy Manager.

Non-Conditioning statement- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of OB-GYN, P.C.

Signature of patient _____ Date _____

Copies of signed authorizations are available upon request.