Camden Ob/Gyn

Disclosure of Protected Health Information

By Law, medical information is confidential unless written authorization is given.

Therefore, I ,_______________________________, authorize Camden Ob/Gyn to release medical information to the following person(s):

Name:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ___________________________________

OR

I request that you DO NOT disclose medical information to anyone other than me.
__________INITIALS

I can be contacted at: Check all that apply:

___ Day Time Phone # _______________________________

___ Home Phone # _________________________________

___ Cell # ____

___ Place of employment # ___________________________

___ Detailed messages and results can be left with the people listed above and/or on voice mail/answering machine listed above.

This authorization remains in effect until I give written notice to discontinue.

Patient/ Parent Guardian Signature: _____________________________________ Date: __/__/__