

Ob/Gyn Associates of Denton

Ob/Gyn Associates of Denton and/or members of the office staff may discuss and/or release your Protected Health Information to: **(Circle YES or NO)**

You: Yes No

Specified Other Persons: Yes No

If yes, please specify to whom this information may be released.

Authorized Person

Phone

Relationship

Protected Health Information may also be released: **(Circle YES or NO)**

Yes No Left on my home voice mail (Ph#) _____

Yes No Left on my office voice mail (Ph #) _____

Yes No Mailed to my home at the address provided below

Yes No Discussed directly over the phone (Ph#) _____

Yes No Faxed to # _____

Address: _____

What information may be released? **Circle YES or NO**

Yes No Lab results

Yes No X-ray/Diagnostic Reports

Yes No Medications

Yes No Medical Status

Yes No Appointments/Appointment Reminders

Yes No Other _____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used on a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that this document is part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I need to notify the physician in writing of these changes.

Printed Name

Patient Signature

Date