EMERALD OBGYN

CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME:_____ DOB:_____

Where are we allowed to attempt to contact you with test results? (please circle)

CELL:	YES	NO	NUMBER:_____
WORK:	YES	NO	NUMBER:_____
HOME:	YES	NO	NUMBER:_____

Many times when calling, we reach voicemail or an answering machine.

Are we allowed to leave a **DETAILED** message with test results? (please circle)

Please note: Test results of a *sensitive nature* will ONLY be given to the patient directly, not left on voicemail or to any family member.

CELL:	YES	NO
WORK:	YES	NO
HOME:	YES	NO

Please list family members to whom we are permitted to release medical information (including appointments, lab/imaging results, diagnoses, treatment, medication, surgeries, etc. except as noted above regarding any *sensitive* information):

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Please list the physicians to whom we are permitted to release medical information:

Doctor:_____ Specialty:_____ Phone:_____

Doctor:_____ Specialty:_____ Phone:_____

Patient Signature:_____ Date:_____