Moreland OB-GYN
Leading Women To Better Health

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Patient Label:

Authorization to Release Protected Health Information (PHI)

It is the policy of Moreland OB/GYN to provide communication with patients by phone or other means designated by you. The practice requires the following authorization for the release of protected health information.

May we leave detailed medical information on your voice mail? ☐ Yes ☐ No
(appointment reminders, billing/payment information, test results etc.)

If yes, please provide the phone number where we can leave information: _____

Authorization for Confidential Communications

I authorize Moreland OB/GYN to release medical information to the following person(s) on my behalf. I understand that I have the right to revoke this authorization at any time, but that any revocation needs to be in writing. I understand that any revocation will not apply to information already released in response to this authorization.

Name of person(s) receiving information: _____

Relationship to patient: _____ Phone: _____

☐ I am **NOT** a minor and am authorizing confidential communications with the person(s) listed above. I wish to keep the following information **confidential**:

Confidential Information: _____

☐ I am a **minor (14-17 years old)** and understand that certain aspects of my medical records are accessible to my parents. I wish to keep the following information **confidential**:

☐ Pregnancy ☐ Birth Control ☐ Drug Use ☐ Smoking ☐ Sexual Activity

X_____ ____/____/____ _____
Patient or Legal Guardian/Representative signature: if not the patient, list legal status Date Time