SYLACAUGA OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent will not allow Sylacauga Obstetrics & Gynecology to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow Sylacauga Obstetrics & Gynecology to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE:

Occasionally, it is necessary for the staff of Sylacauga Obstetrics & Gynecology to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of Sylacauga Obstetrics & Gynecology discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name: _____

Patient Signature: _____ Date: _____