Women's Health Care Group of PA
Great Valley OB/GYN Division

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____ DATE: _____

1. By signing my signature below, I hereby authorize the disclosure of my protected health information (including HIV/AIDS related information, if applicable) to the person(s) listed below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Signature_____ Date_____

2. By signing below, I hereby authorize the practice to leave my protected health information (including but not limited to results, prescriptions and appointments).

☐ **on my answering machine (home): _____**

☐ **on my answering machine (work): _____**

☐ **on my cell phone: _____**

☐ **at my e-mail address: _____**

Patient Signature_____ Date_____

3. By signing below, I hereby authorize the practice to mail appointment reminder letters and other correspondence to my home address.

Patient Signature_____ Date_____

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS OTHERWISE NOTED