AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PERSON(S)

Patient Name: _____Date of Birth: _____

Email: _____

Address: _____Hm Ph.: _____

City/State/Zip: _____Cell Ph.: _____

This form is part of the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of GreatCare OBGYN to release information regarding your healthcare.

Person(s) who can receive information for you:

Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

I hereby authorize GreatCare OBGYN's staff to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying GreatCare OBGYN in writing. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representatives signing the authorization.

_____ _____

Signature of patient or patient's guardian/representative Today's Date