

Shelby OB/GYN, P.C.

Communication Authorization Form

Patient Name: _____

Social Security Number: _____

Any physician, employee or representative of Shelby OB/GYN PC has my permission to verbally discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following person(s) in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
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Name

Relationship

Phone Number(s)

_____	_____	_____
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Name

Relationship

Phone Number(s)

_____	_____	_____
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Name

Relationship

Phone Number(s)

_____	_____	_____
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Name

Relationship

Phone Number(s)

_____ **I do not wish to have test results or other medical information released to anyone other than myself.**

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Shelby OB/GYN PC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

Copy given to patient