Associates *in* Gynecology, Ltd

Authorization to Release Patient Information

Patient Name:_____ Date of Birth:_____

I authorize Associates *in* Gynecology, Ltd to discuss or release my:

Medical Information (lab, x-ray results, etc.) to:

- ☐ **Spouse**
- ☐ **Mother**
- ☐ **Father**
- ☐ **Other:_____**

Account Information (billing, appointment, etc.):

- ☐ **Spouse**
- ☐ **Mother**
- ☐ **Father**
- ☐ **Other:_____**

You may contact me at: (Please indicate which number to call first)

- ☐ **Home # _____**
- ☐ **Cell # _____**
- ☐ **Work # _____**
- ☐ **E-mail _____**

- ☐ **You may leave a message on my voice mail and/or answering machine.**
- ☐ **Do not leave a message.**

Pharmacy Name _____
Pharmacy # _____

- ☐ **I consent to have my prescription history obtained.**

Signature: _____ Date:_____

****Please don't assume no news is good news****

We will make every effort to contact you regarding your test results, so it is imperative that you provide us with your current home, cell and work numbers as well as your address. Thank you for your cooperation.