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**

Associates in Gynecology utilizes our patient portal to notify you of all normal test results.

If you choose not to participate in our patient portal, it will be your responsibility to contact our office during business hours to confirm your normal test results.

You will be contacted by phone regarding any abnormal test results.

Signature: _____ Date: _____