WOMEN'S | Health Care Group of PA
Valley Forge 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 any) 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.**

Patient Signature_____ Date_____

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

Patient Signature_____ Date_____

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS OTHERWISE NOTED