FOLSOM OB/GYN

Folsom Obstetrics & Gynecology
Authorization To Share My Medical Information

In accordance with Personal Health Information (PHI) privacy laws, we are no longer allowed to release information to family members, leave information on voicemail systems, or take treatment requests from family members without your written consent. Please complete the following information.

☐ I **DO NOT** want any of my PHI released to any one except myself for any reason. Please keep my PHI completely confidential and allow only me to make appointments or request prescription refills.

OR

Please list all individuals who ARE authorized to receive your health information.

Name	Relationship
1._____	_____
2._____	_____
3._____	_____

Please list all individuals who may request treatment for you or may call with medical complaints (i.e. medication refills, referrals, treatment for illnesses).

Name	Relationship
1._____	_____
2._____	_____
3._____	_____

Are we allowed to leave information on your home answering machine? Yes ☐ No ☐
Are we allowed to leave information on your work voicemail system? Yes ☐ No ☐
Is there an email address you would like us to use instead? Yes ☐ No ☐
If Yes, _____@_____._____

Are there any specific topics of information that you would like us NOT to release to anyone other then you, including the fore mentioned names? Yes☐ No☐
If Yes, please list these topics
_____

_____

Name_____ Signature_____