OBSTETRIX MEDICAL GROUP

Authorization for Verbal Release of Protected Health Information

☐ **STANDARD DISCLOSURE**

I authorize Obstetrix Medical Group of Texas to discuss my medical history, diagnosis, treatment, prognosis, and financial, insurance and billing information with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointment for me to be seen in the office, hospital or another physicians office.

☐ Spouse_____

☐ Children_____

☐ Parent(s)_____

☐ Other_____

☐ **NO INFORMATION**

I do not authorize release of any verbal information concerning my treatment. I understand that this includes confirmation of appointment dates, times, location and any billing or financial information.

I consent and authorize the release of any test results to be left on my voice mail at my

☐ home ☐ cell ☐ work number Phone Number_____

This authorization will expire at the end of my treatment of Obstetrix Medical Group of Texas unless I revoke the consent prior to that time.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

5/13/2010