BAYSIDE WOMEN'S HEALTH

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

In the event that our office is unable to reach you, the patient, directly concerning (but not limited to) test results, pathology reports, and other medical information, it is up to your discretion with whom we may share this information with. Please refer to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with any questions.

I authorize Bayside Women's Health to discuss my account and medical conditions - which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information - with the following persons in order to facilitate and coordinate my care, treatment, and payment. (please check appropriately):

□ Myself Only

□ Myself and/or those listed below:

1. Full Name: _____
   Relationship: _____
   Phone #: _____

2. Full Name: _____
   Relationship: _____
   Phone #: _____

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can withdraw this permission by signing a new form at any time. This authorization will remain in effect until I change or revoke it.

_____ _____
Patient Name (printed) Date

_____
Signature of Patient

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with _____

_____ _____
Patient Name (printed) Date

_____
Signature of Patient