OB-GYN SOUTH PATIENT RIGHTS & RELEASE CONSENT

PATIENT CONTACT NUMBERS:

Cell number (including area code)_____

Alternate number (including area code)_____

E-mail Address: _____
No Detailed information can be given via e-mail

Detailed information can be given via the Patient Portal if you have registered

Preferred contact method ___ Cell Phone ___Alternate phone ___ Patient Portal

(The questions below will apply to all contact methods)

May we leave a message on voicemail to return our call YES / NO?
May we leave a message on voicemail stating normal test results YES / NO?
May we leave a message on voicemail regarding appointments/prescriptions YES / NO?
May we leave a message with the person answering the phone to return our call YES / NO?

Emergency contact name and number_____

RELEASE OF MEDICAL INFORMATION (OPTIONAL)

I give my permission to release confidential health information to the following people:

Name/Relationship_____Phone _____
DOB _____

Name/Relationship_____ Phone _____
DOB _____

*******Please specify any personal health information you do not want disclosed to the above named people*******

_____

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

_____
PATIENT NAME (PRINT)

_____ _____
PATIENT SIGNATURE (PARENT, LEGAL GUARDIAN & RELATIONSHIP) DATE

*****WRITTEN NOTIFICATION IS REQUIRED FOR CHANGES TO THIS FORM*****