AUTHORIZATION TO RELEASE PATIENT INFORMATION / HIPPA

I authorize The Women's Group of Gwinnett to contact me at the following places:

- Home Telephone ◯Yes ◯No
- Cell Phone ◯Yes ◯No
- Work Telephone ◯Yes ◯No

◯Yes, you may leave medical information (such as test results) on my voicemail.

Cell #___________________________ Home #___________________________

◯No, you may NOT leave medical information on my voicemail.

◯You may discuss my **medical information** with ONLY me.

Please list the names of people with whom we may discuss your **medical information**:

_____________________________________ Relationship____________________

_____________________________________ Relationship____________________

◯You may discuss my **financial information** with ONLY me.

Please list the names of people with whom we may discuss your **financial information**:

_____________________________________ Relationship____________________

_____________________________________ Relationship____________________

I have been informed that a copy of The Women's Group of Gwinnett, P.C. Notice of Privacy Practices is posted on their website and in office.

◯ No, I do not want a copy of the policy but I do acknowledge that it exists.

◯ Yes, I have requested and been given a copy of the privacy policy.

____

Print Name

____ ____________________________

Signature of Patient/Guardian Date

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