NEW BEGINNINGS OB-GYN

PATIENT INFORMATION RELEASE

PATIENT'S NAME: _____ DATE OF BIRTH: _____

As a patient I understand my medical information is **CONFIDENTIAL** and it is the policy of New Beginnings OB-GYN not to release any sensitive information to anyone other than myself, **unless written authorization** has been given. Therefore, in an effort to let the Doctors, Nurses or their designees better communicate my confidential medical information to me or my designated relative/friend, I agree to the following, as indicated by my initials:

_____ I hereby authorize New Beginnings OB-GYN to release information regarding my medical care and/or condition to the following individuals. I understand that this may include sensitive information, such as test results.

AUTHORIZED PERSON (S)	RELATIONSHIP
_____	_____
_____	_____
_____	_____

This authorization is valid until I revoke it in writing.

_____ I do not authorize the release of information regarding my medical care and/or condition to anyone other than myself.

_____ _____
Patient Signature Date

_____ _____
Printed Name Witness

Acknowledgement of Receipt of Notice of Privacy Practices

New Beginnings OB-GYN reserves the right to modify the privacy practices outlined in the notice.

-I have received or have been offered a copy of the Notice of Privacy Practices for New Beginnings OB-GYN.

_____ _____
Patient Signature Date

_____ _____
Printed Name Witness