Fairfax OB-GYN Associates, P.C.

Authorization to Verbally Release Patient Information

Date: ___________

I, ______________________, hereby authorize Fairfax OB-GYN Associates, P.C. and/ or
representatives to release any and all information pertaining to my health care, results, pr
and/or accounting information to the following person's) or agencies.
In order for your bills to be paid it may be necessary to provide your insurance company w
records. Please keep in mind mind that we may only give them that proof if you have marl
appropriately.

Myself ________________ No One ________________

Insurance________________

Spouse ________________

Parents ________________

Other ________________

I further authorize the physicians, nurse practitioners and their representatives to contact r
in one or more of the following ways:

May call me: ________________

At home ________________

At work ________________

May leave message to return call to physician's office:

At home ________________ You may not leave a message

At work ________________

Answering machine________________

I understand that results will NOT be given or discussed over the telephone.
I understand that this office will NOT release any information to those persons who I have
receive this information without a separate consent. I also understand that this relates to
well as account information. If I wish to make changes to the status of this form, I will do s

Patient's Signature: ________________________________ Date: _______________