NEW BEGINNINGS
OB-GYN

Authorization to Release Protected Health Information to Delegate

Patient Name: _____ DOB: _____

By signing this form, I authorize New Beginnings OB-GYN PLLC to disclose protected health information such as office visit consultations, lab tests, x-rays or other test results to the person(s) listed below. I understand that it is my responsibility to update this release if necessary and/or remove delegates.

New Beginnings OB-GYN PLLC may release my protected health information to the following delegate(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

New Beginnings OB-GYN PLLC as a courtesy will contact patients regarding upcoming appointments, lab or tests results. This may include pre-recorded appointment reminders to the numbers provided to our office. Please indicate the manner in which these messages may be left.

_____ Primary contact number (home/work/cell)
Initial

_____ Secondary contact number (home/work/cell)
Initial

_____ Only in person or via direct phone discussion (no messages)
Initial

_____ _____
Patient or Delegate Signature Date

_____ _____
Witness Date