COMMUNICATION CONSENT

It is the office policy of Seasons of Life Obstetrics & Gynecology, PC and its staff not to release confidential and/or unauthorized information by phone, answering machine, voice mail, etc. unless otherwise permitted. When returning telephone calls, we will not leave a message if the name or phone number on the recorded message cannot adequately identify the residence of the patient. Furthermore, patient information will not be disclosed to any unauthorized person who may answer our call.

I authorize Seasons of Life Obstetrics & Gynecology, PC and its staff to leave medical information pertaining to my care by the following methods only and will assume responsibility to notify them whenever this information changes. *Please check all that apply.*

Home Phone:	▫ Yes ▫ No	Home Voicemail:	▫ Yes ▫ No
Work Phone:	▫ Yes ▫ No	Work Voicemail:	▫ Yes ▫ No
Cell Phone:	▫ Yes ▫ No	Cell Voicemail:	▫ Yes ▫ No
Email:	▫ Yes ▫ No	Fax Medical Records:	▫ Yes ▫ No

I authorize Seasons of Life Obstetrics & Gynecology, PC to release medical information to the following individuals in my absence.

Please list names of authorized individuals.

Spouse: _____ ▫ Yes ▫ No

Parent: _____ ▫ Yes ▫ No

Other *(please list name and relationship to patient):*

_____ ▫ Yes ▫ No

_____ ▫ Yes ▫ No

Patient Name *(printed):* _____

Patient/ Guardian Signature: _____ Date: _____

Relationship to Patient: _____

_____