ADVANCED OB-GYN
Obstetrics & Gynecology
230 Michigan St. NE, Suite 102, Grand Rapids, MI 49503 616-971-0060

VOLUNTARY PATIENT AUTHORIZATION RELEASE OF PROTECTED HEALTH INFORMATION

① AGREEMENT

I understand that this authorization is Voluntary, and that I may refuse to sign. In refusing to sign, my refusal will not affect my ability to obtain treatment.

I authorize Advanced OB-GYN to use or disclose my individual protected health information for the purpose of: (check all that apply)

- ☐ Scheduling and cancellation of appointments
- ☐ Billing, insurance process
- ☐ Physician's notes, prescriptions, samples
- ☐ Obtaining lab results, speaking to the physician or assistant

I understand that the information I authorize another person or entity to receive may be re-disclosed by them, and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time **in writing** to Advanced OB-GYN. However, the revocation will not be valid to the extent that Advanced OB-GYN has already taken action on this authorization, or to the extent this authorization is executed as a condition for obtaining insurance coverage.

This authorization does **NOT** permit the use and disclosure of health care information for marketing purposes. This authorization expires automatically ten years after date below unless otherwise indicated.

② HOW WE MAY COMMUNICATE WITH YOU

I wish to be contacted in the following manner (check all that apply)

☐ Home telephone: _____
☐ OK to leave message with detailed information
☐ Leave a message with call-back number only
☐ OK to leave a detailed message on answering machine
☐ OK to leave detailed message on voicemail
☐ OK to leave message with the following person(s):

☐ Alternate/Cell Telephone: _____
☐ OK to leave message with detailed information
☐ Leave a message with call-back number only
☐ OK to leave detailed message on voicemail

③ OTHER PEOPLE WE MAY DISCLOSE YOUR INDIVIDUAL PROTECTED HEALTH INFORMATION TO

_____ _____
Name Relationship Name Relationship

_____ _____
Name Relationship Name Relationship

④ SIGNATURE

Patient Signature: _____

Print Name: _____

Date: _____ Date of Birth: _____