

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, procedure 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 with records. Please keep in mind that we may only give them that proof if you have marked appropriately.

Myself	<input type="checkbox"/>	No One	<input type="checkbox"/>
Insurance	<input type="checkbox"/>		
Spouse	<input type="checkbox"/>		
Parents	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

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

May call me:	<input type="checkbox"/>
At home	<input type="checkbox"/>
At work	<input type="checkbox"/>

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

At home	<input type="checkbox"/>	You may not leave a message	<input type="checkbox"/>
At work	<input type="checkbox"/>		
Answering machine	<input type="checkbox"/>		

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 procedure as well as account information. If I wish to make changes to the status of this form, I will do so.

Patient's Signature: _____ Date: _____