EMERALD COAST
Obstetrics and Gynecology

103 E. 23rd Street, Panama City, FL 32405 | Phone: 769-0338 | Fax: 850-785-6088

RELEASE OF PATIENT INFORMATION

I, _____, authorize Emerald Coast OB/GYN to use and disclose my Protected Health Information to carry out treatment, payment, and other care operations. I understand that Emerald Coast OB/GYN works hard to protect my privacy and preserves the confidentiality of my Protected Health Information.

Your Protected Health Information is any information as it relates to your past, present, or future physical or mental health condition or payment of your health care.

This information can include spoken or written facts used for the purpose of treatment, payment or healthcare operations as their terms are defined in federal HIPAA privacy rules. This consent also gives permission for any listed person(s) you designate below, access to your Protected Health Information.

Emerald Coast OB/GYN may refuse treatment if you (or an authorized representative) do not sign the consent form. You may revoke your consent in writing, except to the extent the practice has already made disclosure and reliance upon your prior consent. If you do not consent to the Protected Health Information, or later revoke, Emerald Coast OB/GYN may refuse to provide treatment.

I HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED TO ME AND I HAVE RECEIVED A SIGNED COPY OF THIS FORM.

_____ _____ _____

Patient Signature or Authorized Representative | Date of Birth | Date

_____ _____

Printed Name | Relation to Patient (if applicable)

THE NAMES LISTED BELOW ARE AUTHORIZED TO HAVE ACCESS TO MY PROTECTED HEALTH INFORMATION

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____