VERBAL DISCLOSURE OF INFORMATION AUTHORIZATION

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS / SIGNIFICANT OTHERS

Name of Patient: _____Date of Birth: _____/_____/_____

I hereby authorize medical providers and personnel of ***Women's Health of Central Massachusetts*** to discuss my protected health information with:

- ☐ No one
- ☐ Spouse / Significant Other (name)_____Phone_____
- ☐ Parent (name)_____Phone_____
- ☐ Other (relationship)_____(name)_____Phone_____

I understand that certain information cannot be released without specific authorization as required by state or federal law.
By **initialing the lines below**, I authorize the release of the following protected or sensitive information:

_____Information regarding the patient's diagnosis and treatment for HIV/AIDS
_____Psychotherapy notes from a Psychiatrist or Psychotherapist
_____Information regarding pregnancy or childbirth
_____Information regarding sexually transmitted diseases
_____Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from until at which time this authorization to use or disclose this protected health information expires. Unless specified above, this authorization will expire 365 days from the date of signing. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that WHCMA has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient or Patient's Representative Date
*Print Name of Representative & Describe Authority here*_____

MESSAGES FROM OUR OFFICE: YOUR PREFERENCES

The providers and staff at ***Women's Health of Central Massachusetts*** may need to contact you by phone for notifications such as appointment confirmations or cancellation as well as to communicate with you concerning your health (example: test results, post-operative inquiries, etc.). The information you provide below will guide us regarding your preferred contact method (cell, home, work phones) and the level of information you would like left on answering systems or with other persons answering the phone in the event you are not available.

Please indicate your preferred contact method and level of information you wish us to provide:

	Circle one			Phone Number	Level of Message
1st Phone you would like us to call:	Cell	Home	Work		☐ brief message ☐ extended message
2nd Phone you would like us to call:	Cell	Home	Work		☐ brief message ☐ extended message

_____ _____
Signature of Patient or Patient's Representative Date