8605 S. EASTERN AVE SUITE C

PHONE: 702-671-0006

FAX: 702-252-3000

Authorization for Release of Information to Family Members

Patient Name: ______________________________ Date of Birth: __________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of **HIPAA** we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing release to family member you must sign this form. Signing this form will only give information to the people listed below.

Individuals:

1.____ Relation to Patient: _________________________

2.____ Relation to Patient: _________________________

3.____ Relation to Patient: _________________________

I authorize **GyneCare** to release my medical and/or billing information to the people mentioned above.

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. Furthermore, I understand that the information disclose to any above recipient is no longer protected by the federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: ____ Date:________________________________