Women's Health TEXAS

Release of Protected Health Information

Patient Name: _____ **DOB:** _____

I grant permission for my healthcare provider and their representatives of WHTX to discuss my care, as it becomes relevant, using this disclosure form to share information about my healthcare or discuss financial information for payment on my account with family or friends.

Are there any specific people you would like the staff at WHTX to disclose medical/appointment information to?

WE WILL NOT TALK TO ANYONE THAT IS NOT ON THIS FORM, INCLUDING YOUR SPOUSE, PARENT OR CHILDREN.

Release my protected health information to the following person(s)/entity:

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone:_____ Relationship: _____

The information you may release subject to this authorization is the following:

Appointment date/time: ☐ **Yes** ☐ **No** Explanation of diagnosis and/or procedures: ☐ **Yes** ☐ **No**

Lab reports: ☐ **Yes** ☐ **No** Billing information: ☐ **Yes** ☐ **No**

_____ _____

Patient / Guardian Signature Date

----------OR----------

☐ **I <u>do not</u> want any of my information shared with family or friends**

_____ _____

Patient Signature **Date**

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Women's Health Texas.

Oakwood Women's Centre

Renaissance Women's Group

The OB/GYN Group of Austin

women health partners in Obstetrics & Gynecology

Westlake Gynecology

Wildflower OB|GYN