

Southern Indiana OB/GYN

Health Information Release Form

Due to HIPAA laws, our office is unable to release information to anyone other than the patient and/or parent and legal guardian without your written permission.

If you would like to have someone other than yourself be able to receive information regarding your present medical condition, please list their name(s) and relationship to you below:

Please release information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ **Date:** _____
Please Print

Patient Signature: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices issued by Southern Indiana OB/GYN.

Patient Signature: _____

Preferred method of contacting patient:

Cell Phone

Home Phone

Alternative Phone

By Mail-Address