MOSCOW PULLMAN OB/GYN

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Authorization to Verbally Release Health Care Information

I, _____, _____
(Name) (DOB)

☐ **DO AUTHORIZE** the Providers and Staff of Moscow Pullman OB-GYN to verbally release or discuss my health and medical information to the following:

Name	DOB	Relationship

Please Specify if you do not want the Providers and Staff of Moscow Pullman OB-GYN to discuss the following medical information.

I DO NOT AUTHORIZE the following information to be shared.

_____ Drug and/or Alcohol abuse treatment
_____ HIV (AIDS) testing and/or treatment
_____ Psychiatric Conditions
_____ Sexually Transmitted Disease or Illness

☐ **I DO NOT AUTHORIZE** the Providers and Staff of Moscow Pullman OB-GYN to verbally release or discuss my health and medical information with **ANYONE**.

I choose to have this authorization expire:
_____ No Expiration _____1 Year _____ Following event or condition

Specify:_____

I understand that I can revoke, update, or change this form at any time in writing. The termination of this authorization to release Protected Health Information is effective on the date that the Physician's office receives it. It does not apply to any information released prior to the date of the receipt of the written termination.

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date