DALE R MYERS MD
SALLY WHITMAN PA-C
Gynecology/Women's Health

PATIENT AUTHORIZATION - DISCLOSURE OF PROTECTED HEALTH INFORMATION

For Test Results I prefer initial call made to: HOME CELL WORK

Appointment reminders: TEXT EMAIL PHONE CALL (Circle all that you prefer)

____Home Phone – ok to leave messages regarding appointments or request call to our office

____Cell Phone – ok to leave message with detailed information

____Work Phone – ok to leave message with call back number

I HEREBY GIVE MY AUTHORIZATION TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE SPECIFIC INDIVIDUAL(S) LISTED BELOW. PLEAS CHECK ALL THAT APPLY.

_____ I do not want you to speak to anyone (other than my primary care physician, or physician being referred to by this office, if applicable)

_____ It is acceptable for you to speak with only the following individual(s) regarding my condition **(please check all that apply and provide their name(s):**

_____ Spouse: _____

_____ Parents/Guardians: _____

_____ Siblings: _____

_____ Children: _____

_____ Medical Providers: _____

_____ Other: _____

This authorization will expire on _____ (expiration date or defined event).
If no date/defined event indicated, authorization will remain in place until further notice.

It is the patient's responsibility to notify office staff of any changes to this authorization. A copy of this authorization is considered valid.

Patient Name_____ DOB_____

_____ _____
Patient/Responsible Party Signature Date