Authorization to Communicate Protected Health Information

I understand that my healthcare information at Oakdale Obstetrics and Gynecology, P.A. (Oakdale), is protected and I was given the opportunity to read and receive a copy of Oakdale's Notice of Privacy Practices.

The name(s) listed below are family members or friends to whom I wish to grant access to healthcare information. I will rely on the professional judgment of my provider and my provider's clinical staff to share such healthcare information, as they deem necessary.

I understand that information is limited to verbal discussion of clinical concerns and/or diagnoses with clinical staff and that no paper copies of my protected healthcare information will be provided without my signature on a Patient Authorization and Request for Use and Disclosure of Protected Health Information form.

I understand that some information is considered sensitive. I understand that I must check the specific boxes in order for my provider's clinical staff to release any sensitive information such as:

- ☐ *Mental Health/Psychiatric Disorders (including depression)*
- ☐ *Chemical Dependency (drug and or alcohol abuse/treatment)*
- ☐ *HIV/AIDS Virus*
- ☐ *Sexually Transmitted Diseases*

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it in writing at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

	Name	Relationship
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________

Patient Name: ______________________________ DOB: ______________
Please Print

Patient Signature: ___________________________ Date: ______________