NORTH FLORIDA OB GYN LLC

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name of person allowed to receive information	Type of information which may be released
Mother	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Father	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Husband	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC

☐ **NO INFORMATION TO BE RELEASED**

This consent to release information will remain in effect until revoked in writing.

_____ _____ _____

Print Patient's Name Signature Patient Date

_____ _____ Division: _____

Staff Witness Date

January 2013