Riverside
OBSTETRICS
&
GYNECOLOGY

Patient Information Release to Family Member or Other Person

I, _____, authorize Riverside OB/GYN, P.C. to release any information contained in the medical record of the patient identified above, which includes information that may be stored in paper or electronic format. This includes all medical information as well as information concerning human immunodeficiency (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ACR), human papillomavirus (HPV), sexually transmitted diseases, and other test results. This also includes appointment information.

The patient listed above may revoke this authorization at any time. Revocations to the authorization must be presented in writing. This authorization is good for one year past the signature date. This consent must be updated annually.

Name of person to whom information is to be disclosed to **AND** relationship to the patient:

_____

(NAME) (RELATIONSHIP)

If you do not want any information released to a family member or other person(s) that you could potentially authorize, please check the box below and sign. This authorization can always be revoked to be changed in the future.

☐ **DO NOT RELEASE ANY OF MY INFORMATION**

This consent was signed by: _____

(PRINT NAME PLEASE)

SIGNATURE: _____ **Date:** _____