Texas Perinatal Group
911 W. 38th Street, Suite #201
Austin, Texas 78705
(512) 459-1131

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1._____

2. _____

3. _____

4. _____

___ Yes ___No The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

__□ Home Voice Mail or Answering Machine Home Phone number: _____

__□ Cell phone Cell phone number: _____

__□ Work Voice Mail Work phone number: _____

__□ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____
Print Name of Patient *Print Name of Authorized Representative

_____ _____
Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

o Parent/legal guardian o Power of Attorney

*Evidence of authority must be provided and on file with the practice.