Arrowhead Obstetrics & Gynecology

Date_____

RELEASE OF INFORMATION

Please read document before filling out form

I, _____, give my consent to the staff of Arrowhead Obstetrics & Gynecology to relay any lab, radiological testing or any other imperative information to including but not limited to referral information, medication refills, etc.

Please check the following:

YES	NO	
_____		SELF ONLY (we can only leave information with you)
_____	_____	Answering machine, voicemail or any other answering service device
_____	_____	_____ (name) _____ (relationship)
_____	_____	_____ (name) _____ (relationship)

Best telephone number to contact me is at:_____

Patient/Guardian Signature_____

Patient/Guardian Print Name_____

NOTICE: By signing this form, you understand the policy

In accordance with federal HIPAA regulations, **we can only release information to persons or leave messages on alternative sources (i.e. answering machine, voicemail) indicated on this signed, origional form**. We cannot accept a verbal authorization to leave test information to persons or sources not listed on the form.
You may update your release of test information at any time. If you need to update any information, a new Release of Test Information form must be filled out and signed. Thank you.