Permission for Disclosure of Protected Health Information.

I, _____, give my permission for South OKC Women's Healthcare to give information to the people listed below about my medical care. This information may include lab results, medications being taken, appointment times, changes in appointments, Ultrasound results, doctor or nurse reports about me and any other information that this office has about me. (Please do NOT include other physicians or your employer in this list) it is my responsibility to keep the office updated on any changes in my personal information.

_____Relationship

_____Relationship

_____Relationship

_____Relationship

_____Relationship

_____ _____

Signature of Patient Date

_____ _____

Witness Signature Date

OPPORTUNITY TO OBJECT

I,_____, do not want any information given to anyone but myself regarding my healthcare status or other patient information.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

Witness Signature Date