Seattle
Obstetrics & Gynecology Group
OB/GYN

Authorization to Release Personal Information

I, ______________________________ authorize Seattle OB/GYN Group to:
(Please check all that apply)

☐ Leave a detailed message on my home phone:___________________________

☐ Leave a detailed message on my cell phone:_____________________________

☐ Leave a detailed message on my work phone:____________________________

☐ Speak to or leave a detailed message with my spouse or partner:

Name:______________________________ Phone number :__________________

☐ Speak to or leave a detailed message with another family member or friend:

Name:______________________________ Phone number :____________________

Relationship:________________________

☐ DO NOT release any information to the following individuals:

____

With my signature below, I acknowledge that this information will be kept in my medical record and abided by until updated or revoked by me in writing. I also acknowledge that it is my responsibility to notify my healthcare provider should I change any or all of the phone numbers listed above.

Patient Signature: _______________________________________ **Date:** ____________