OBSTETRIX MEDICAL GROUP

Authorization for Verbal Release of Protected Health Information

☐ **STANDARD DISCLOSURE**

I authorize Obstetrix Medical Group of Houston to discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse, as well as, confirmation of any appointments for me to be seen in the office, hospital or at another physicians office.

☐ **Spouse** _____

☐ **Children** _____

☐ **Parent(s)** _____

☐ **Other** _____

☐ **NO INFORMATION**

I do not authorize release of any information concerning my treatment. I understand that this includes confirmation of appointment dates, times and location.

This authorization will expire at the end of my treatment with Obstetrix Medical Group of Houston unless I revoke the consent prior to that time.

_____ _____

Signature of Patient Date

_____ _____

Witness Date