LENOX Healthcare for Women

Authorization To Release Medical Information
To Members of Your Family or Other Individuals

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in order for your physician or the staff of Lenox Healthcare for Women to discuss your condition with members of your family or other individuals that you designate other than your *Primary Care Doctor*, we must obtain your authorization due to the severity of your medical condition. The law stipulates that these rules may be waived.

____ **I AUTHORIZE** Lenox Healthcare for Women to verbally release any or all information concerning my medical care to the following individuals:

_____	_____	_____
Name (Please print clearly)	Relationship	Phone Number
_____	_____	_____
Name (Please print clearly)	Relationship	Phone Number

____ **I <u>DO NOT</u> AUTHORIZE** Lenox Healthcare for Women to release any or all information concerning my medical care

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<u>Voice Mail</u>

____ **I AUTHORIZE** Lenox Health Care for Women to leave a detailed mail message on the following phone or phone numbers: _____

____ **I <u>DO NOT</u> AUTHORIZE** Lenox Healthcare for Women to leave a detailed voice mail message.

_____	_____
Printed Patient Name	Printed Name of Authorized Representative

_____	_____	_____
Patient or Authorized Representative Signature	Relationship	Date

Patient unable to sign. Verbal consent given. Reason: _____