Wendover OB/GYN and Infertility, Inc.

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care: _____

_____

Check all that may apply:

- ☐ All my medical information to include:
  Information necessary to schedule appointments for me
  Lab or test results
  Information necessary to provide, call in or pick up prescriptions for me
  Information necessary to help my family member(s) take care of me
  Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of the Practice unless OR until I notify the Practice in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient