

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