<u>Westlake GYN / Neeta Ambe-Crain, M.D.</u>

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS, AND OTHERS AS DIRECTED BELOW

Patient Name:______________________________ Date of Birth____________

I authorize **Westlake GYN** to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

If necessary, **Westlake GYN** may talk with my spouse or significant other about my medical condition and/or billing. The name of the person is ____. ____Yes ____No

If necessary, **Westlake GYN** may talk with my parents or with my caregiver about my medical condition and/or billing information. The names of my parents ore caregiver are ____. ____Yes ____No

Rights of the Patient

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: **Westlake GYN.**
I understand that any change in this authorization is effective from the date signed going forward.
I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand I have the right to refuse to sign this authorization. This authorization shall be in effect until revoked by the patient.

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Signature of Patient, Parent or Guardian   Date

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Printed Name of Patient, Parent or Guardian

03/22/17