PERMISSION TO GIVE MEDICAL INFORMATION

I _____, hereby inform the physicians and staff of Eastside Gynecology &
(Patient or Parent/Guardian)
Obstetrics PC, the designated parties below have my authorization to request and receive the release of any protected health information related to treatment concerning myself (my child's) health and wellbeing. This includes, but not limited to, appointments, treatment, medications, test results, payment, billing statement, general medical care, or administrative operations.

1.	Name	Relationship	Phone #
2.	Name	Relationship	Phone #

_____ I authorize the staff at Eastside to leave a **voicemail** with test results for **MYSELF (or my child)** at the numbers
(yes/no) indicated on the patient's demographic form.

_____ I authorize the staff at Eastside to leave a **voicemail** with test results with the **AUTHORIZED PERSON(s)**
(yes/no) listed on this form.

GENERAL CONSENT FOR TREATMENT

I hereby consent to medical treatment, diagnostic procedures and injections by providers and staff of Eastside Gynecology & Obstetrics, P.C. I understand diagnostic procedures may include, but are not limited to lab tests including HIV testing, urine, and tissue. I understand I may be asked to undergo diagnostic radiology procedures including, but not limited to, ultrasound. I understand I have the right to ask questions about my treatment and/or procedures and I agree to notify my provider of my concerns.

NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative of the patient, acknowledges that he or she personally read the posted Eastside Genecology & Obstetric, P.C.'s NOTICE OF PRIVACY PRACTICES on the date listed below. A copy will be provided if needed.

_____ _____

Patient or Parent/Guardian signature Date

_____ _____ _____

Print **Patient** Name Print **Guardian name and relationship**

If delay in treatment results because we cannot reach you, Eastside Gynecology & Obstetrics, P.C. will not be held responsible.

5/20/2018 LL