



GREENSBORO
OB-GYN ASSOCIATES
a division of Piedmont Healthcare for Women, P.A.
personalized care for every woman

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Designated Party Release

You may give Greensboro OB/GYN written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or another party that you designate.

Patient Name: _____ Date of Birth: _____

Date: _____

At my request, I authorize Greensboro OB/GYN to disclose my protected health information to
(enter name of person/entity who will receive your protected health information):

Name: _____

Address: _____

Phone Number: _____ Relationship to Patient: _____

Leave detailed message on my home answering machine (phone number: _____)

Leave detailed message on my voice mail at work (phone number: _____)

Leave detailed message on cell phone voice mail (phone number: _____)

Leave detailed message with (name and relationship: _____)

I understand that I may revoke this authorization at any time by giving Greensboro OB/GYN written notice. However, if I revoke this authorization, I also understand that the revocation will *not* affect any action Greensboro OB/GYN took in reliance on this authorization before receipt of written notice of revocation.

Signature: _____

Date Authorization Revoked: _____

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