HIPAA RELEASE

Under the HIPAA Privacy Regulations, the patient may allow access to their Protected Health Information (PHI). Please Complete Below:

☐ **I DO NOT WANT ANY information discussed with anyone.**

OR

By completing below, you are granting Middlesex OB/GYN, permission to discuss your protected health information (PHI) with whomever you indicate on the line below.

☐ **Middlesex OB/GYN may discuss my PHI with person(s) indicated below:**

_____, _____

(Print name of person) (Relationship to patient)

Please check below what may be discussed

Test/Lab Results ☐ **Yes** ☐ **No** **Entire Medical Record** ☐ **Yes** ☐ **No**

Make and/or Cancel appointments ☐ **Yes** ☐ **No**

_____ _____ _____

(Print Patient Name) ****Required** (Patient Signature) ****Required** (Date) ****Required**

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This form is valid from date of signature until the patient requests in writing that these permissions be negated. Unless signed by patient, this form will be invalid***