Woman to Woman
Obstetrics and Gynecology Associates

Casandra Hicks Autry, M.D., F.A.C.O.G.
Board Certified Physician

Authorization for Release of Protected Health Information

I authorize the staff and physicians of Woman to Woman Obstetrics & Gynecology to discuss my health care, diagnosis, test results, procedures, prognoses, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered:

_____ _____

Name of Designated Person **Relationship to Patient**

_____ _____

Name of Designated Person **Relationship to Patient**

☐ **I DO NOT WISH TO DESIGNATE ANY PERSON(S)**

*Please note: For patients under 18 years of age, NO information will be released to the parent or legal guardian with regards to the treatment of sexually transmitted diseases, treatment of drug or alcohol abuse, medical treatment for sexual assault, pregnancy services or prenatal care, contraceptives or abortion, unless so designated above.

I authorize the release of my Protected Health Information to the following physician(s) or facility upon request of the physician(s) or facility for the purpose of treatment:

_____ _____

Name of Physician or Facility **Type of physician or facility**

_____ _____

Name of Physician or Facility **Type of physician or facility**

_____ _____

Name of Physician or Facility **Type of physician or facility**

☐ **I DO NOT WISH TO DESIGNATGE ANY PHYSICIAN(S) OR FACILITY**

I wish to have the staff and or the physician(s) at Woman To Woman Obstetrics & Gynecology leave messages on the answering machine at my home or with any individuals who may answer my phone. These messages may include, but are not limited to: appointment confirmation, lab results, radiology results, pathology results, etc.

☐ **I DO WISH TO HAVE MESSAFES LEFT** ☐ **I DO NOT WISH TO HAVE MESSAGES LEFT**

Patient Signature_____ **Date: ____/____/____**