Disclosure Authorization

Your privacy is important to us. Current healthcare regulations require us to safeguard your protected health information (PHI) which includes virtually everything about you and your healthcare status. If you want us to be able to leave messages with or share other information with anyone else, or if you want us to be able to leave you voicemail messages, you must fill out and sign this form.

Patient name: _____

Date of birth: _____ Social security number: _____

I authorize Accent on Women's Health to

☐ share protected health information with the people listed below.

Name	Phone	Relationship

☐ leave messages that may contain protected health information on voicemail at the number below and I accept responsibility for securing any messages left there.

Authorized voicemail number: _____

APPOINTMENT REMINDERS: We will contact you one business day prior to your scheduled appointment with a reminder. Please choose your preferred method of contact:

☐ Voicemail Ph#_____

☐ Text Message #_____

☐ Email _____

Signature _____ Date _____